Employer: Mercer University

Claim for Reimbursement

Name:______________________________ **Social Security #____________________**

Dependent Care Expense Claims

Name of Dependent	From	To	Name, Address & Taxpayer ID # of Provider	Total Amount
XXXXXXXXXXXXX XXXXXXXXXXXXX	XXXXX XXXXX	XXXXXX XXXXXX	Total Dependent Care Expense Claim	

Note: The Total Amount claimed under the Plan for any coverage period must not exceed the lesser of your earned income for the plan year or the earned income of your spouse. If your spouse is either a full-time student or is incapable of taking care of himself or herself, then he or she is deemed to have monthly earnings of $200 if there is one child and $400 if there are two or more. No payment may be made under the Plan if the service provider is your dependent for federal income tax purposes, or is your child or your stepchild and is under age 19.

Unreimbursed Medical Expense Claims

Date Incurred	Name of Service Provider	Expense Description	Person for whom Exp Incurred	Net Amount
XXXXXX XXXXXX XXXXXX	XXXXXXXXXXXXXX XXXXXXXXXXXXXX XXXXXXXXXXXXXX	XXXXXXXXXXXXXX XXXXXXXXXXXXXX XXXXXXXXXXXXXX	Total Medical Care Exp Claim	

READ CAREFULLY

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the University's Cafeteria Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

____ _____________________________

Employee's Signature **Date**

Refer to the Reimbursement Account section of your Employee Benefit Handbook for additional assistance. If you have questions regarding your Reimbursement Account balances or concerns about submitting a claim, please call Core Administrative Resources, (912) 741-3521 or (888) 741-2673.