REIMBURSEMENT REQUEST FORM

Glynn Griffing and Associates, Administrators
P. O. Box 16509, Jackson, MS 39236-6509
www.glynn.info

(601) 982-0331
fax (601) 981-3829
If you fax, do not mail

Employer Name: The University of Mississippi

Employee Name: _____

Phone: _____ **E-Mail:** _____ **Employee ID #:** _____

Please complete this form in its entirety. Attach a written statement from an independent third party for each amount claimed stating that the expense has been incurred, the nature of the expense, the amount of the expense, and the date(s) of service. Cancelled checks, Balance Forward, Paid on Account Receipts will not be acceptable.

Medical Care Expenses

Date of Service	Name of Person for Whom Expense was Incurred	Relationship to Employee	Name of Entity Providing Service	Description of Service	Reimbursement Amount
TOTAL					

Dependent Day Care Expenses

Beginning Date of Service	Ending Date of Service	Name of Dependent For Whom Expenses Were Incurred	Age of Dependent	Relationship to Employee	Name of Entity Providing Service	Description of Service	Reimbursement Amount
TOTAL							

All Dependent Care receipts must include the tax ID number and signature of provider.

To the best of my knowledge and belief, the expense(s) listed on this voucher are accurate and complete and are eligible for reimbursement under the Plan. I certify that these expenses will not be claimed again when filing IRS form 1040. I certify that these expenses were incurred for eligible family members.

I certify that any medical or dependent care expenses have not been reimbursed and are not reimbursable under any other coverage. With regard to dependent care expenses, I certify that I will include the name, address, and taxpayer identification number of the service provider on my income tax return. I certify that dependent care expenses have not been paid to anyone claimed as a dependent on my income tax return.

I certify that if my employer incurs a liability for failure to withhold Federal, State or Local Income taxes or Social Security Taxes on one or more payments or reimbursements that are not Qualifying Expenses, I will indemnify and reimburse the employer that liability on demand.

_____ _____

Employee's Signature **Date**