Glynn Griffing & Associates
Professional Service. Personal Care.

P.O. Box 16509
Jackson, MS 39236

Reimbursement Request Form

Login at https://glynn.info to submit online claims, check account balances, and more.

Do not use this form when submitting documentation for Benefit Card claims!

Total Pages Submitted:

Plan Year Beginning: ______________________ Ending: ______________________
Plan Year are you requesting your eligible expenses to be paid from

Employer Name: ______________________

Employee Name: ______________________ SSN: ______________

Address, If changed: ______________________

Email: ______________________ Phone: ______________
Used to send important emails about claims

Please complete this form in its entirety. Attach a written statement from an independent third party such as an Itemized Statement, Explanation of Benefits (EOB), or pharmacy printout of prescriptions for each amount claimed. Documentation must include the date(s) of service, the provider of services, what procedure(s) was done, and the amount you are being charged. Charge receipts, cancelled checks, balance forwards, and paid on account receipts are NOT 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 Services	Reimbursement Amount

Dependent Day Care Expenses

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

Beginning Date of Service	Ending Date of Service	Dependent for Whom Expenses were Incurred	Age of Dependent	Relationship to Employee	Name of Entity Providing Service	Description of Service	Reimbursement Amount

To the best of my knowledge and belief, the expense(s) listed on this voucher are accurate and completed and are eligible for reimbursement under the Plan. I certify that these expenses will not be claimed again when filing IRS from 1040. I certify that these expenses were incurred for eligible family members. I certify that any Health Premium claimed in my Premium Reimbursement Account is qualified under the terms of the Plan.

I certify that any medical or dependent care expense(s) 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 tax payer 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 of demand.

______________________ ______________
Employee Signature Date