



HEALTH CARE FLEXIBLE SPENDING ACCOUNT (FSA)

REIMBURSEMENT REQUEST FORM

PLEASE PRINT

EMPLOYEE NAME		DATE OF BIRTH		SOCIAL SECURITY NUMBER	
EMPLOYEE ADDRESS	IS THIS A NEW ADDRESS?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	CITY	STATE
NAME OF QUALIFYING DEPENDENT					REALTIONSHIP TO EMPLOYEE
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LOCATION	AKRON DEPT. NO.	TERR. NO.	PLANT LOCATION	SUBSIDIARY	

Total amount submitted for reimbursement consideration \$ _____

NOTE: All reimbursements from your Health Care Flexible Spending Account (FSA) will be made directly to you.

Supporting documentation must accompany this request form, documentation includes the following:

- Explanation of Benefit (EOB) Statement(s) indicating deductible and co-payment from any Medical/Dental/Vision Plan(s) under which you and/or any of your eligible dependents are covered.
- Itemized bills from doctors or other suppliers for health care expenses not covered by your Medical/Dental/Vision Plan(s), which state the amount of the expense and that the Health Care Expense has been incurred. (Balance due Statements from Providers are not acceptable as itemized bills.
- Itemized sales receipts for the over-the-counter (OTC) medications including antacids, pain relievers, and cold and allergy medications.

1. Retain copies of supporting documentation for your records as those submitted will not be returned.
2. Items which are **not eligible** for reimbursement through the FSA are charges for services incurred in a prior year and/or Dependent Day Care expenses. For Dependent Day Care expenses please complete the Dependent Day Care reimbursement form.
3. Remember, you must wait until you have at least \$25 in claims before submitting for reimbursement unless it is at year-end or your account balance is less than \$25.
4. Multiple claims may be submitted on one Health Care Reimbursement Request Form.
5. The employee's Social Security Number **MUST** be shown on all receipts/invoices to ensure correct processing.

NOTE: Any items for which you are reimbursed cannot be claimed as deductions or credits on your Federal Income Tax Return.

I certify that the health care expenses for which reimbursement is requested have not been reimbursed or are reimbursable under any other health plan coverage, and that the expenses incurred are for myself or my eligible dependents.

Employee Signature _____ Date _____

Please submit the completed form to: **The Goodyear Benefits Solution Center
P.O. Box 52040
Phoenix, AZ 85072-2040**