DO NOT EMAIL YOUR SOCIAL SECURITY NUMBER
PLEASE REMOVE IT FROM ALL EMAILED FORMS!

2021
REQUEST FOR REIMBURSEMENT
from
EMPLOYEE FLEXIBLE SPENDING ACCOUNT

COMPANY: OCCIDENTAL COLLEGE **(Last four digits only)**

EMPLOYEE: ________________________________ SSN: 000-00-________________________

MEDICAL EXPENSE ACCOUNT - OVER THE COUNTER ITEMS ARE NOW RESTRICTED

Attach copy of itemized receipt, bill or insurance statement showing name of person receiving service, the date, type and provider of service, amount charged for the service and amount covered by insurance, if applicable. You will not be reimbursed for any medical expenses before the service has been rendered. Documentation of your expenses must be third party documentation. Only copies of checks or credit card receipts are not acceptable, and All Dates of Service must be showing on receipt.

$________________________ ______________ to ______________________

Total Amount of Requested Medical Expense — **FIRST** date of service to **LAST** date of service (not when billed or paid)

DEPENDENT DAY CARE ACCOUNT

Attach copy of statement or receipt showing dates of service, care provider's name and social security or tax identification number, place of service, dependent's name(s) and age(s), and amount charged for service. You will not be reimbursed for any dependent day care expenses before the service has been rendered. Your documentation of your expenses must be third party documentation. Only copies of checks or credit card receipts are not acceptable, and All Dates of Service must be showing on receipt.

$________________________ ______________ to ______________________

Total Amount Requested — **FIRST** date of service to **LAST** date of service

PREMIUM SPENDING ACCOUNT

Attach copy of insurance bill or statement showing name of insurance carrier, type of insurance, amount charged for coverage, name of covered family member(s), and period of coverage. You will not be reimbursed for any insurance premiums before the coverage has been provided. Documentation of your expenses must be third party documentation. Only copies of checks or credit card receipts are not acceptable, and All Dates of Service must be showing on receipt.

$________________________ ______________ to ______________________

Total Amount Requested — **FIRST** date of service to **LAST** date of service

To the best of my knowledge and belief, my statements in this Request are complete and true. I am claiming reimbursement only for eligible expenses **incurred during the applicable plan year** for myself, my spouse, or my eligible dependents. I certify that these expenses have not been and will not be reimbursed to myself, my spouse, my eligible dependents, or the service provider, under this or any other benefit plan and will not be claimed as income tax deductions. I further certify that any request I make for reimbursement from my Dependent Care Account is for employment-related dependent care expenses. I authorize my Flexible Spending Account to be reduced by the amount requested.

Employee Signature ________________________________ **Date** ____________________

SEND THIS FORM AND APPROPRIATE DOCUMENTATION BY FAX, MAIL OR EMAIL TO:

CETERA RETIREMENT PLAN SERVICES
2125 Oak Grove Road, Suite 105, Walnut Creek, CA 94598
Email at: michelle.vargo@cetera.com or FAX (855) 300-8368