SSA
Support. Services. Alliance.
an Excellus company

Mail Claim To:
SSA, Inc.
165 Main Street
Oneida, NY 13421-1699
(800) 491-6584

FLEXIBLE SPENDING PLAN

REIMBURSEMENT REQUEST FORM

PERSONAL INFORMATION

Employer	For Plan Year	St. Lawrence ID Number

Employee Name (Last) (First) (Initial)

Home Address Street City State Zip

☐ Health Care Account ☐ Dependent Care Account ☐ ID# of Daycare Provider_____

PERSONAL INFORMATION

Name of Employee, Child or Dependent Receiving Service	Relationship to Employee	Dates of Service From	Dates of Service To	Amount To Be Reimbursed	mySource Card

Grand Total

AUTHORIZATION

I certify that the expenses for reimbursement requested from my Health Care Reimbursement Account (HCRA) and/or Dependent Care Reimbursement Account (DCRA) were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by another plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my HCRA and/or DCRA. I (or we) understand that expenses reimbursed through the HCRA and/or DCRA accounts can not be used as deductions or credits when filing my (our) income tax return.

Employee Signature _____ **Date** _____

Please review this form carefully. Forms improperly completed will be returned and may result in a delay in your reimbursement. Please submit a copy of the bill(s) or an explanation of benefits from your other insurance.