

J. N. MORCOS INSURANCE
P O BOX 98
AURORA, IL 60507
630-892-3900

FLEXIBLE SPENDING ACCOUNT - MILEAGE RECORD
MILEAGE REIMBURSEMENT REQUEST FORM

Employee Name: _____ SSN: _____

Street Address: _____

City, State, Zip: _____

Instructions: This form is to be completed if you are claiming, under your Health Care Spending (FSA), the mileage used to obtain qualified medical services from a physician, hospital or facility to prevent or alleviate a physical disease, defect or illness. Mileage will be reimbursed at a rate consistent with current Federal Guidelines. Be sure to provide all information requested on this form. If the form is incomplete, it will be returned to you. Print or type the information requested, sign and date the form.

Please print and include driving directions showing mileage from your home to the provider from a website (such as mapquest) with this request form.

Travel Date: ____/____/____

Name and address of facility traveled to:

Reason for Travel: _____
Describe medical treatment / service(s)

Patient Name: _____

Beginning Odometer Reading: _____ Ending Odometer Reading: _____

Total number of miles traveled to and from the above listed destination: _____

The current mileage reimbursement rate is 19 cents per mile effective January 1, 2011. (Subject to Change)

Total amount of requested reimbursement: _____
Total number of miles traveled multiplied by the reimbursement rate.

To the best of my knowledge and belief, my statement in this Mileage Record Reimbursement Request Form is complete and true. I certify that I have incurred the miles described above on the dates indicated. I certify that the mileage was only used to obtain qualified medical services from a physician, hospital or facility to prevent or alleviate a physical disease, defect or illness. I have not been reimbursed previously under the Employers Benefit Plan or any other Benefit Plan, nor do I expect any of these expenses to be reimbursable elsewhere. I understand that these expenses may not be used to claim any Federal income tax deduction or credit. **WARNING: Any person, who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud or health care fraud under state and /or federal law.**

Employee Signature Date

Print Name