SECTION 125 FLEXIBLE SPENDING

TML MultiState Intergovernmental Employee Benefits Pool

UNREIMBURSED HEALTHCARE REIMBURSEMENT FORM

PO Box 140167 | Austin, Texas 78714-0167 | Fax: (512) 719-6505

GRACE PERIOD PLAN

Plan Year: _____

Employer Name			Employer Group #	
Employee Name			Social Security #	
Street Address	City	State	Zip Code	☐ Check here if new
Mailing Address	City	State	Zip Code	☐ Check here if new

Description of Eligible Expense	Incurred Date	Total Amount of Bill	Amount paid by any Plan	Amount to be Reimbursed	Expense for: (*Name*)
		$	$	$	
		$	$	$	
		$	$	$	
		$	$	$	
		$	$	$	
	TOTAL	$	$	$	

AUTHORIZATION: I certify the above information to be correct and true to the best of my knowledge and that any children listed are dependents under Section 152 of the Internal Revenue Code. I understand that any amounts remaining in my account(s) not used for expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws with additional two (2) month-fifteen (15) day grace period. I also understand that the Flexible Spending reduction(s) will be in effect for the plan year and cannot be revoked unless I experience a change in my family status, significant change in cost or coverage of my health plan or my spouse's health plan or separation from service as prescribed by IRS rules. If a change in family status occurs, you have thirty-one (31) days from the occurrence to change or revoke your election. Furthermore, I hereby authorize my employer to transfer my required health benefits contribution on a monthly basis to the TML MultiState Intergovernmental Employee Benefits Pool. I agree to only submit claims which qualify as expenses under Section 213, Internal Revenue Code.

_____ _____

Employee Signature Date

Please return this form to your TML MultiState IEBP.