



TML Intergovernmental Employee Benefits Pool  
 PO Box 140167  
 Austin, Texas 78714-0167  
 Fax: (512) 719-6505



**UNREIMBURSED HEALTHCARE REIMBURSEMENT FORM**

Employer Name <b>San Marcos</b>			Employer Group # <b>ASANMAR1</b>		
Employee Name			Unique Identification Number		
Street Address	City	State	Zip Code	<input type="checkbox"/> 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)
_____	_____	\$ _____	\$ _____	\$ _____	_____
_____	_____	\$ _____	\$ _____	\$ _____	_____
_____	_____	\$ _____	\$ _____	\$ _____	_____
_____	_____	\$ _____	\$ _____	\$ _____	_____
_____	_____	\$ _____	\$ _____	\$ _____	_____
<b>TOTAL</b>		\$ _____	\$ _____	\$ _____	

**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. 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 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 Intergovernmental Employee Benefits Pool. I agree to only submit claims which qualify as expenses under Section 213, Internal Revenue Code.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date