Salary Stretcher Plus
Request For Reimbursement Form

Name ______________________________________

Address ____________________________________

City ____________________ State ______ Zip __________

Phone ___________________

PHONE: 515-462-5827, Ext. 155

MAIL: Agriland FS, Inc.
Attn: Accounts Payable
421 N. 10th Street
Winterset, IA 50273

E-MAIL: accountspayable@agrilandfs.com

For each claim line entered, all boxes must be completed. Thank you.

Date of Service (Not billing or paid date) MO.	YR.	Benefit Code*	Claim Amount	Service Type List Service Provider(s)

BENEFIT CODES*

D - Dependent Care/Daycare

To the best of my knowledge and belief, my statements in this Request for Reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants. I certify that these expenses have not been previously reimbursed under this or any other benefit plan and will not be claimed as an income tax deduction. I understand that the IRS regulates my Flex System account and that these guidelines are implemented as a means of ensuring compliance and approval for reimbursement. I further understand that it is my responsibility to comply with these guidelines and to avoid submitting duplicate or ineligible claims, as that may delay payment. I authorize my Flexible Spending Account to be reduced by the amount requested.

Employee Signature_________________________________ Date_______________