REQUEST FOR REIMBURSEMENT

Client ID#: **4701-9830-5604 - The McClatchy Company**
Participant ID#: _____
Name: _____
Address: _____
City/State/Zip: _____
Day Time Phone Number: _____

☐ New Address: Check here and update – Please Print

_____

_____

RECEIPTS MUST BE SUBMITTED WITH REQUEST

Submit Request for Reimbursement:

BY E-MAIL: service@tasconline.com

BY FAX: 608-663-2762

BY MAIL: TASC
PO Box 7308
Madison, WI 53707-7308

Date of Service
(not billing or paid date)

Month	Day	Year	Benefit Code	Service Code	Request Amount	Service Provider (s)
					.	
					.	
					.	
					.	

BENEFIT CODES:

M – MEDICAL EXPENSE – OUT OF POCKET
D – DEPENDENT CARE / DAY CARE
T – TRANSPORTATION

SERVICE CODES:

MD – MEDICAL **VS** – VISION **RX** – PRESCRIPTION DRUGS **DN** – DENTAL **OT** – OVER-THE-COUNTER
MP – MEDICAL PREVENTION **DC** – DEPENDENT CARE **PK** – PARKING **MT** – MASS TRANSIT

To the best of my knowledge and belief, my statements in this Request for Reimbursement are complete and true. I am requesting reimbursement for eligible expenses incurred during the applicable Plan Year and for eligible Plan Participants. I certify that these expenses have not previously been 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 FlexSystem account and that these guidelines are implemented as a means of ensuring compliance and approval for reimbursements. I further understand that it is my responsibility to comply with these guidelines and to avoid submitting duplicate or ineligible requests, as doing so may delay payment. I authorize my Flexible Spending Account balance to be reduced by the amount requested.

EMPLOYEE SIGNATURE
(required) _____ Date ___ / ___ / ___