CITY OF ST. AUGUSTINE

Health, Wellness, and Dependent Care Reimbursement Form

(Please prepare on computer or in ink)

Employee Name _____ EE # _____

Period of expenses from _____ Thru _____

Itemization of expenses (Substantiating receipts and/or explanation of benefits required)

Expenses: Please list descriptions, provider, vendor, or establishment paid and amounts						
Description	Amounts					Totals
Total Reimbursement						

Signatures

Employee _____ _____

Department Head _____ _____

Human Resources Director _____ _____

If submitted to Human Resources by the Thursday before the pay period ends, you will be reimbursed that pay period.

The employee acknowledges, by way of his or her above signature, that if he/she leaves the employment of the City within one (1) year of reimbursement, the employee shall refund the City the amount of such reimbursement, except as stipulated in the policy. The reimbursement may be deducted from the employee's last paycheck. In addition, the above may be subject to Federal taxes.