

# FLEXIBLE SPENDING ACCOUNT CLAIM FORM

COMPANY NAME:

FPS FILE:

FOR PLAN YEAR \_\_\_\_\_ THROUGH \_\_\_\_\_

Please print or type

**NOTE: THIS FORM CAN ONLY BE USED FOR SERVICES INCURRED DURING THE PLAN YEAR SHOWN ABOVE.**

Soc. Sec. Acct. No. \_\_\_\_\_

Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Day phone (\_\_\_\_) \_\_\_\_\_  
Employee name

Number & street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Employee home address Please check here if this is a change in address

(please make additional copies of this form for future claims)

### Health Care Request

These services **MUST** have been incurred during the current plan year as shown on the top of this form.

You **MUST** attach a copy of the provider's bill or insurance company's "Explanation of Benefits" verifying the date of service, type of service, name of person receiving service and the cost, to the back of this form.

Use additional sheets if necessary.

Date	DATE AND TYPE OF SERVICE(S) INCURRED & COST			Total amount of attached bills, EOB's, etc. \$ _____
	Type	For whom	Cost	
_____	_____	_____	\$ _____	Less Amount(s) from other sources. \$ _____
_____	_____	_____	\$ _____	
_____	_____	_____	\$ _____	
_____	_____	_____	\$ _____	

See IRC Section 213 for qualifying Health Care expenses or consult your tax advisor for more information.

**TOTAL HEALTH CARE AMOUNT REQUESTED**

\$ \_\_\_\_\_ 1

### Dependent Day Care Request

These services **MUST** have been incurred during the current plan year as shown on the top of this form.

You **MUST** attach a copy of the provider's bill or a receipt verifying the name of the care provider, the provider's Tax I.D. or Social Security Number and signature, the date(s) of service and the cost, for **ALL** requests, to the back of this form.

Use additional sheets if necessary.

#### DEPENDENT CARE PROVIDER INFORMATION & COST

1. Provider's Name \_\_\_\_\_ Tax I.D. or Soc. Sec.# \_\_\_\_\_  
Date(s) \_\_\_\_\_ Cost \$ \_\_\_\_\_
2. Provider's Name \_\_\_\_\_ Tax I.D. or Soc. Sec.# \_\_\_\_\_  
Date(s) \_\_\_\_\_ Cost \$ \_\_\_\_\_

See IRC Section 129 for qualifying Dependent Care expenses or consult your tax advisor for more information.

**TOTAL DEPENDENT CARE AMOUNT REQUESTED**

\$ \_\_\_\_\_ 2

### Premium Reimbursement Account

This is for reimbursement of insurance premiums paid by you for your personal medical, dental, vision and/or disability insurance. **DO NOT REQUEST REIMBURSEMENT FOR PREMIUMS YOUR EMPLOYER PAYS.** A copy of your insurance company's "premium due notice" or bill **MUST** be attached to the back of this form and cannot be returned.

Use additional sheets if necessary.

#### INSURANCE POLICY INFORMATION & COST

1. Insurance Co. \_\_\_\_\_ Period of coverage \_\_\_\_\_  
Type of insurance \_\_\_\_\_ Premium Cost \$ \_\_\_\_\_
2. Insurance Co. \_\_\_\_\_ Period of coverage \_\_\_\_\_  
Type of insurance \_\_\_\_\_ Premium Cost \$ \_\_\_\_\_

**TOTAL PREMIUM REIMBURSEMENT AMOUNT REQUESTED**

\$ \_\_\_\_\_ 3

To the best of my knowledge and belief, my statements on this Request for Reimbursement are complete and true. I understand that I am solely responsible for the validity of claims submitted to my Flexible Spending Account. I am claiming reimbursement only for eligible expenses incurred by myself, spouse and/or dependents during the plan year shown above and certify that these expenses have not been reimbursed under this plan or by any other source and that they will not be reimbursed by any other source or insurance.

I hereby authorize my Flexible Spending Account to be reduced by the amount(s) shown above.

Participant's signature **X**

Date \_\_\_\_\_