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FLEXIBLE BENEFITS CLAIM FORM

PLEASE READ AND COMPLETE THE FOLLOWING BELOW:

EMPLOYER: PHONE NUMBER: ( ) -

EMPLOYEE'S NAME SS#

Please note: In most circumstances, claims must first be submitted to your insurance carrier. When you receive an Explanation of Benefits (EOB), attach a copy to this claim form.

When an EOB is not applicable, (e.g. co-payments, vision care, and other non-covered expenses), please submit receipt.

TOTAL UNREIMBURSED MEDICAL, DENTAL, ETC. $_____

TOTAL DEPENDENT DAY CARE $_____

I certify that these expenses have not been reimbursed and I will not seek reimbursement for them under a major medical plan or any other health plan, such as an individual policy or my spouse's or dependent's health plan. I understand that the expense for which I am reimbursed may not be used to claim any federal income tax deduction or credit.

_____ _____
EMPLOYEE SIGNATURE **DATE**

DEPENDENT CARE REIMBURSEMENT STATEMENT

Day care provider must complete Affidavit if you do not have an actual paid receipt.

I have provided child/adult care for _____ _____
Dependent Name Age

For the period beginning _____ and ending _____
Date Date

Services were provided to _____ for fee of $_____
Employee Name

Name_____ Signature _____ Date_____

Address_____ Tax ID/SS#_____

I certify that these expenses have not been reimbursed and I will not seek reimbursement for them under a major medical plan or any other health plan, such as an individual policy or my spouse's or dependent's health plan. I understand that the expense for which I am reimbursed may not be used to claim any federal income tax deduction or credit.

_____ _____
Signature Date