

CLAIM FORM

Employee: _____ Email Address: _____

Social Security No: _____ Employer: _____

For each of the accounts, please include documentation in the order you have listed and attach to this claim form. NOTE: Cancelled Checks or credit card receipts/statements are not valid forms of documentation.

Health FSA

Dates of Service	Type of expense (i.e., eye exam)	Dollar Amount
1.		\$
2.		\$
3.		\$
4.		\$
5.		\$
Claim Total		\$

Dependent FSA

Please provide the following information. A statement from the day care provider listing:

*Date(s) of service, *Charges, *Provider's signature *or Provider's signature on daycare provider letterhead

Date(s) of Service	Dependent Name	Dependent Age(s)	Dollar Amount
1.			\$
2.			\$
3.			\$
Claim Total			\$

Provider of Dependent Care Statement

Name:	Telephone:
Address	City, State, Zip
Tax ID or Social Security Number	NOTE: Prepare to file IRS form 2441 with your tax return.

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my reimbursement plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return. **Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.**

Signature: X _____ Date: _____