Flexible Benefit Plan
Reimbursement Claim Form

Employer: _____

Employee Name: _____ Social Security Number: _____

Phone: _____ Email: _____

Dependent Care Expense Claims

Name of Dependents	Period Covered From	To	Name, Address, and Taxpayer Identification Number of Service Provider	Amount Incurred
➔ *Attach a receipt from your day care provider, or include the day care provider's signature.*			**Provider's Signature:**	
			Total Dependent Care Expense Claim*	$0.00

*NOTE: The total amount claimed under the Plan for any coverage period must not exceed the lesser of your earned income for the Plan Year or the earned income of your spouse. (If your spouse is either a full-time student or is incapable of taking care of himself or herself, then he or she is deemed to have monthly earnings of $250 if there is one (1) child or dependent, or $500 if there are two (2) or more.) No payment may be made under the Plan; if the service provider is your dependent for federal income tax purposes; or is your child or stepchild and is under age 19.

Unreimbursed Medical Expense Claims

Date Expense Incurred (mm/dd/yy)	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount
➔ *Attach appropriate receipt(s) and submit with this claim form.*			**Total Medical Care Expense Claim**	$0.00

Read Carefully: The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the Company's Flexible Benefit Plan with respect to such expenses and that the medical expenses have not been reimbursed and that the undersigned will not seek reimbursement under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

_____ _____

Employee's Signature Date