

Employee Benefit Claim Form



1. Please provide all requested information for each claim and sign the form. 2. Attach an **itemized statement** for each of your expenses which include the date and type of service. **Canceled checks, credit card slips, or balance due statements are NOT allowed.** 3. Keep your original claim form and supporting documents for your records. 4. When faxing claims do not follow-up with a hard copy via mail.

Part I: Employee Participant Information (Please Print)

Employee Participant Name:		Company Plan Sponsor Name:		
Street Address:		City:	State:	Zip:
Phone:	Email Address:		SSN:	
Check ONE : <input type="checkbox"/> New Claim <input type="checkbox"/> Resubmitted Claim <input type="checkbox"/> Debit Card Substantiation				

Part II: Medical Flexible Spending Account Reimbursement

List the expense which you are requesting reimbursement for. Please read your Summary Plan Description for a list of your eligible expenses.

Date of Service	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Reimbursement Amt Requested
☞ Please attach all appropriate receipts and submit with this claim form.			Total Reimbursement Requested:	

Part III: Dependent Care Expenses (Child or elder care expenses)

If your employer sponsors and you participate in a Dependent Care Plan, please read your Summary Plan Description for a list of your eligible expenses.

Name of Dependent(s)	Dep(s) Age	Dates of Service		Day Care Provider Information			Reimbursement Amt Requested
		From	To	Name	Address	Tax ID	
☞ Please attach all appropriate receipts and submit with this claim form, or include Provider's signature in the space below.				Total Reimbursement Requested:			
				☞ Day Care Provider's Signature:			

Part IV: Employee Certification

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 Employer sponsored Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable 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 re-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 (Required): _____ Date: _____