

Flexible Spending Account Claim Form

Employer: _____
 Employee Name: _____ Employee # or Social Security # : _____
 Check here if new address Address: _____
 City: _____ State: _____ Zip: _____ Date of Birth: _____
 Email: _____ Phone: _____

You can also file your claim online at www.myflexonline.com "File a Claim" and then print the form and mail, fax, or e-mail it to us!

TO EXPEDITE YOUR CLAIM: Provide **ALL** appropriate information, including photocopies of receipts, and review the total dependent care and/or total health care expense amounts before submitting.



2008 - NEW CHANGE TO DEBIT CARD RECEIPTS.
Please HOLD ALL receipts until requested through a letter from us! Fewer receipts will be required due to the changes in merchant inventory codes 1/1/2008.

ONLY Flex Spending Take Care® DEBIT CARD TRANSACTIONS REQUIRING A RECEIPT (letter sent requesting this)			
Date of Service	Name of Service Provider	Expense Description	Amount
Flex Take Care® Debit Card Transactions (requiring receipt)			\$

DEPENDENT CARE REIMBURSEMENT			
Name of Dependents	Period Covered From To	Name, Address, and Taxpayer Identification Number of Service Provider	Amount
Provider's Signature (required if not on receipt)			Total Dependent Care Claims (to be reimbursed) \$

HEALTH CARE REIMBURSEMENT EXPENSES NOT PAID BY Flex Spending Take Care® DEBIT CARD			
Date of Service	Name of Service Provider	Expense Description	Amount
View Your Account Online at www.myflexonline.com			Total Health Care Claims (to be reimbursed) \$

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 Spending Benefit Plan with respect to such expenses and that the health 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 validity and accuracy 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. Please do not include original receipts, since, after the claim is substantiated, your receipts may not be readily accessible. **Claims will not be processed unless all above information is completed.**

 Employee's Signature Date