Health Care & Dependent Care Flexible Reimbursement Form

(See instructions on reverse side)

Mail claims to the address indicated on your ID card.

EMPLOYEE INFORMATION - MUST BE COMPLETED (Please Print)

Employee's Name (last, first) ______ Social Security # ___-__-____ Group/Fund Number ______

Address ______ City ______ State ______ Zip Code ______

HEALTH CARE EXPENSES - MUST BE COMPLETED; ATTACH SUPPORTING DOCUMENTATION (see instructions on reverse)

Patient's Name	Date of Service		Description of Service/Supply	Provider	A. Total Charges	B. Amount Paid by Other Health Care Plans	C. Amount to be Reimbursed A-B=C
	From	To					
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
						Total Reimbursement Request	$

DEPENDENT CARE EXPENSES - MUST BE COMPLETED; ATTACH SUPPORTING DOCUMENTATION (see instructions on reverse)

1. Dependent's Full Name	Birth Date	Date of Service		Type of Service	Amount to be Reimbursed
		From	To		
	/ /	/ /	/ /		
Provider's Name & Address		Provider's Tax ID Number*			

2. Dependent's Full Name	Birth Date	Date of Service		Type of Service	Amount to be Reimbursed
		From	To		
	/ /	/ /	/ /		
Provider's Name & Address		Provider's Tax ID Number*			

3. Dependent's Full Name	Birth Date	Date of Service		Type of Service	Amount to be Reimbursed
		From	To		
	/ /	/ /	/ /		
Provider's Name & Address		Provider's Tax ID Number*			

*If provider is self-employed, enter Social Security Number. If a provider is a tax-exempt organization, enter "Tax Exempt."

Total $

I hereby certify that:

- ***The information given on this reimbursement form is complete and correct.***
- ***I have not received reimbursement for these expenses from the Reimbursement Account or from any other source.***
- ***The total of reimbursed dependent care expenses does not exceed the lesser of my or my spouse's earned income (W-2 Pay) for the year, if less than $5,000.***
- ***All health and dependent care expenses listed above comply with requirements and guidelines listed on the back of this form.***

This authorizes my insurance company, prepayment organization, employer, hospital, physician, or pharmacy (or any of their agents) to release or receive all information with respect to myself or any of my dependents for use in connection with the administration of this plan or any other plan providing benefits or services to me, to any of my dependents, or for related health benefits services.

✗ ______ Employee Signature

______ Date