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Benefit Year ____________________

FLEXIBLE SPENDING ACCOUNT CLAIM FORM

To help avoid claim processing delays, you must sign, date and complete this form. You must also include supporting documentation.

Last Name ____________________ First Name ____________________ M.I. ________

Employer ____________________ Social Security Number ____________________

Medical Flexible Spending Account

Date Expense Incurred	Patient Name	Type of Service (i.e. deductible, dental, medical, pharmacy, and vision)	Service Provider	Amount
Total Medical Expenses				

Dependent Care Flexible Spending Account

Start Date	End Date	Service Provider's Name and EIN or SS#	Dependent's Name	Age	Amount
Total Dependent Care Expenses					

For Medical FSA: I certify that I, my spouse, or eligible dependent have incurred the expenses listed. These expenses are eligible medical care. I understand that "incurred" means the service has been provided.

For Dependent Care FSA: I certify that I have incurred the dependent care expenses for me and, if applicable, my spouse to work. These expenses are for my qualifying person. These qualify as eligible expenses under the plan. I understand that "incurred" means the service has been provided. I acknowledge that I will have to report the caregiver's name, address, and tax identification number on Form 2441.

I have not received reimbursement for any of these expenses. I will not seek reimbursement elsewhere. The undersigned fully understands that he or she alone is fully responsible for the sufficiency and accuracy of all information, 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 on amounts paid from the plan which relate to such expense. The undersigned further understands that no dependent care tax credit or medical expense tax deduction is permitted for amounts for which reimbursement is made.

Employee Signature ______________________________ Date ____________________