

FLEXIBLE SPENDING & DEPENDENT CARE ACCOUNT CLAIM FORM

Fax: 877-767-8821

www.claritybenefitsolutions.com

Part I: Participant	Information	(Please	Print)

Company Name:
Double broad ID
Participant ID:
Participant Name (Last/First/MI):
Participant E-mail:



Part II: Medical Reimbursement Request

Please include an itemized bill, itemized receipt or Explanation of Benefits for medical expenses.

	Date of Service Beginning Date to Ending Date	Provider's Name	Primary or Dependent and Relationship	Expense Description	Reimbursement Requested
1					
2					
3					
4					
5					
6					
7					
8					
	Total Reimbursement Requested >>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>			\$	

Part III: Dependent Care Reimbursement Request

Please attach either a bill, receipt or letter from the Provider which contains the following: Provider name, Dependent name, Dependent age or date of birth, date type of service(s) provided, date(s) of service and the amount paid.

	Date of Service Beginning Date to Ending Date	Provider's Name	Provider Tax ID #	Dependent's Full Name and relationship	Reimbursement Requested
1					
2					
3					
4					
5					
	Total Reimbursement Requested >>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>				\$

TO EXPEDITE CLAIM PAYMENT, PLEASE COMPLETE AND SIGN YOUR CLAIM FORM

Part IV: Employee Certification for Reimbursement

I hereby certify that:

- * All expenses for which reimbursement is requested under the Plan were incurred by myself or, my eligible dependents in compliance with all applicable laws and regulations.

 * Expenses have been paid by me and that in the case of qualifying medical expenses, they have not been reimbursed or are not reimbursable under any other medical coverage; and
- * I will not use qualifying medical expenses reimbursed through my medical reimbursement account as deductions when filing my Federal Income Tax return.

- * I am fully responsible for the sufficiency and accuracy of all information relating to medical claims which are provided by me; and
- * Reimbursement of Dependent Care expenses will reduce and may eliminate completely my ability to claim a dependent care credit on my personal income tax return;
- * Dependent care expenses reimbursed through this account cannot be used as a dependent care credit on my personal tax return; and
- * I hereby authorize release of payment through my Flexible Spending Account'(s).

Emplo	vee Signature:	Date:	

^{*}You can also add an email address on our website www.claritybenefitsolutions.com