Flexible Spending Account (FSA) Reimbursement Claim Form

(This claim form is to be used for the intent of **FSA** expenses **ONLY**)

(DO **NOT** USE FOR TAKE CARE CHARGES OR HEALTH REIMBURSEMENT ACCOUNTS)

Employee Name: _____ Employer Name: _____

Address: _____ Social Security Number: _____

City/St/Zip: _____ Phone #: _____

Dependent Care Expense Claims

Name of Dependents	Period Covered From	To	Name, Address, and Taxpayer Identification Number of Service Provider	Amount Incurred
Attach a receipt from your daycare provider, or include the daycare provider's signature.			**Provider's Signature:**	
			Total Dependent Care Expense Claim*	

*NOTE: The total amount claimed under the Plan for any coverage period must not exceed the lesser of your earned income for the Plan Year or the earned income of your spouse. (If your spouse is either a full-time student or is incapable of taking care of himself or herself, then he or she is deemed to have monthly earnings of $250 if there is one (1) child or dependent, or $500 if there are two (2) or more.) No payment may be made under the Plan; if the service provider is your dependent for federal income tax purposes; or is your child or stepchild and is under age 19.

Unreimbursed Medical Expense Claims

Person for Whom Expense Incurred	Name of Service Provider	Date Incurred	Expense Description	Amount You Are Responsible For
Attach appropriate receipt(s) and submit with claim form.			**Total Medical Care Expense Claim**	

DIRECT DEPOSIT IS AVAILABLE (DOWNLOAD FORM FROM WWW.CPNFLEX.COM)

Read Carefully: When filing your claim, you must attach copies of the receipts. The receipt must include the service provider's name and the date and type of service for each expense. Canceled checks, credit card slips, or statements of balance due are not acceptable. If you fax your claim forms and receipts, please do not follow up with hardcopy. Always retain a copy of all forms and receipts. You may make copies of this form for your future use.

The undersigned participant in the Plan certifies that all services for which reimbursement is claimed by submission of this form were provided during a period while the undersigned was covered under the Company's Cafeteria Plan and that the medical expenses have not been nor will be reimbursable under any other health plan coverage. The undersigned understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim provided by the undersigned, and that unless an expense for which 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.

_____ _____

Employee's Signature Date

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