

FLEXIBLE SPENDING ACCOUNT CLAIM FORM

Employee Name: _____

Current Date: _____

Employee SSN: _____

Type of Expense: Medical Reimbursement \$ _____ **(Attach Receipts)**

Dependent Care \$ _____ **(Attach Receipts)**

Total Claims: \$ _____ **(Attach Receipts)**

To the best of my knowledge and belief, my statements in this Flexible Spending Account Claim Form are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants. I certify that these expenses have not been previously reimbursed under this or any other benefit plan and will not be claimed as an income tax deduction. I authorize my Flexible Spending Account to be reduced by the amount requested.

Employee Signature: _____ Date: _____

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FOR HUMAN RESOURCES USE ONLY

Date Received: _____

HR Approval #1: _____

HR Manager: _____

Date to Payroll: _____

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FOR PAYROLL USE ONLY

Date Received: _____

Date Paid: _____

Amount Paid: _____