

## FLEXIBLE SPENDING ACCOUNT CLAIM FORM

Company Name: \_\_\_\_\_ Page \_\_\_\_\_ of \_\_\_\_\_

Employee Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

E-mail: \_\_\_\_\_ Phone: \_\_\_\_\_

### Medical Care Expense Claims

Date of Service	Name of Service Provider	Nature of Service (description)	Name of Person Cared For/Relationship	Amount
★ You MUST attach receipt(s) to support each expense claimed			<b>Total Medical Care Expenses</b>	

### Dependent Care Expense Claims

Name of Dependent(s)	Date(s) of Service		Name, Address, & Taxpayer Identification No. (or Social Security No.) of Service Provider	Amount(s) Charged
	From	To		
★ Attach receipt(s) from your provider to support your claim – OR – Have the provider verify the charges listed above and sign the claim form →			<b>Total Dependent Care Expenses*</b>	
			<i>Provider's Signature:</i>	

**\*NOTE:** The total amount claimed under the Plan for any coverage period must not exceed the lesser of your wages or salary for the Plan Year or the wages or salary 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 child or dependent, or \$500 if there are two 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.

**Read Carefully:** The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the above-mentioned Section 125 Plan with respect to such expenses, and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, 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 including federal, state, or city income tax on amounts paid from the Plan which relate to such expense. The undersigned further understands that no medical expense deduction or credit is permitted for amounts for which reimbursement is made.

\_\_\_\_\_  
**Employee's Signature (REQUIRED)**

\_\_\_\_\_  
**Date**

MAIL Claim Form and Receipts to: Human Resource Administrators, Inc., PO Box 8, Center Valley, PA 18034

FAX Claim Form and Receipts to: (610) 282-4216

FOR MORE CLAIM FORMS OR TO CHECK YOUR ACCOUNT BALANCE, VISIT [WWW.HRADMINISTRATORS.COM](http://WWW.HRADMINISTRATORS.COM)  
AND CLICK ON THE EZFLEZPLAN ICON OR THE FORMS TAB.