FLEXIBLE SPENDING ACCOUNT CLAIM FORM

Mail or Fax Claim To: **Benefit Extras, Inc.**
P.O. Box 1815
Burnsville, MN 55337
Phone: (952) 435-6858; toll-free (866) 435-6858
Fax: (952) 435-8435; toll-free (800) 886-8793

1. Employer/Employee Information (Must be completed)

Employer

Employee Name

Complete address below ONLY if it has changed

Street

City State Zip

2. Instructions for Completion

- Fill out the date, description and amount of expense, attach receipts, **sign** and date the form. Eligible receipts **must** include provider name, date of service, service provided and cost.
- **Note:** Canceled checks, copies of checks, credit card statements and credit card slips are not receipts.
- Claims will be processed upon receipt, compliant with the sufficient balance requirement for dependent care and individual health insurance premium spending accounts.
- The summary plan description provides eligibility rules for unreimbursed medical, dependent care and individual health insurance premium type expenses.

3. List of Expenses

Healthcare:

Date Expense Incurred	Description of Expenses	Amount
	Total	**$**

Individual Health Insurance Premiums:

Coverage Period (i.e. month)	Amount
Total	**$**

Dependent Care Expenses:

Name Of Provider	Provider Tax ID#	Dependent Name	Age	Dates of Service	Amount
				Total	**$**

Dependent Care Provider Signature (Required unless submitting a receipt) **Date**

4. Employee Certification

I, the undersigned, certify that the above expenses were incurred by me (and/or my spouse/or eligible dependents), have been paid by me (or them), were not reimbursed by any other plan, and to the best of my knowledge and belief are eligible for reimbursement under my account. I have attached WRITTEN PROOF (receipts) of these expenses and I (or we) will not use the expenses reimbursed through this account as deductions or credits when filing my (our) individual income tax return. If audited, I understand that it is my responsibility (not my employer's) to provide written proof that these expenses were actually incurred and eligible for reimbursement. In the event that any reimbursement that I may claim and receive under this plan is later determined by the IRS to be unsubstantiated, I hereby acknowledge and accept responsibility for any adverse tax consequences that may result to me. I understand the employer does not accept responsibility for direct payment to any individuals other than the employee.

X_____ _____

Employee Signature (Required) **Date**