

Mail or Fax Claim To: **Benefit Extras, Inc.**
P.O. Box 1815
Burnsville, MN 55337
Phone: (952) 435-6858

Flex Spending
Accounts Claim Form
Fax: (952) 435-8435

1. Employer/Employee Information
(Must be completed)

| |
|---------------|
| Employer |
| Employee Name |

Complete address below ONLY
if it has changed

| | | |
|-------------|---------------|-----|
| Street | | |
| City | State | Zip |
| Soc. Sec. # | Date of Birth | |

2. Instructions for Completion

- Fill out the date, description and amount of expense, attach receipts, **sign** and date the form. If applicable, indicate whether the claim is to be paid under the Grace Period provision of the Plan (not available with all Plans).
- 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 spending accounts.
- The summary plan description provides eligibility rules for unreimbursed medical and dependent care expenses.

3. List of Expenses

| Health: | *Date Expense Incurred | Description of Expenses | Amount |
|-----------------|------------------------|-------------------------|--------|
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| Total \$ | | | _____ |

***GRACE PERIOD (does not apply to all employer groups – consult your employer for details)**
 By checking this box, I am requesting the attached claim(s) be reimbursed with carry over dollars from the last plan year under the Grace Period provision of the Plan. I understand that by not checking the box, my claim will be processed under the plan year in which the expense(s) was incurred and that I may **NOT** request the claim be re-processed at a later date. The Grace Period provision does **NOT** apply to the Dependent Care Account.

| Dependent Care: | | | | | |
|------------------------|------------------|----------------|-------|------------------|--------|
| 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**

PLEASE RETAIN A COPY FOR YOUR RECORDS!