

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)

2. Instructions for Completion

Employer <hr/> Employee Name <hr/> <p style="text-align: center;">Complete address below <u>ONLY</u> if it has changed</p> Address Line 1 <hr/> Address Line 2 <hr/> City, State and Zip Code <hr/>	<ul style="list-style-type: none"> • 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 spending accounts. • The summary plan description provides eligibility rules for unreimbursed medical and dependent care expenses.
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3. List of Expenses

Health:	*Date Expense Incurred	Description of Expenses	Amount
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
		Total \$	_____
Dependent Care:			
Name	Provider	Dependent	Dates
Of Provider	Tax ID#	Name	of Service
_____	_____	_____	_____
_____	_____	_____	_____
		Total \$	_____
Dependent Care Provider Signature		Date	
(Required unless submitting a receipt)		_____	

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!