



FOR INTERNAL USE ONLY

Reviewed By: _____ Plan Year: _____
 Approval Date: _____ Denial Date: _____

Employer Name: _____ Employee Name: _____ Street Address: _____
 Soc. Sec. No.: _____ - _____ - _____ City: _____ State: _____ Zip: _____
 Daytime Phone: _____ Evening Phone: _____

PLEASE SEE REVERSE SIDE FOR DETAILED INSTRUCTIONS.

PLEASE CHECK ALL INSURANCE COVERAGES THAT COVER YOU OR YOUR DEPENDENTS: MEDICAL DENTAL VISION PRESCRIPTION

HEALTH CARE FSA SECTION

Patient's Full Name	Soc. Sec. No.	Date of Birth	Date(s) of Service <small>(example: 03/23/02 to 03/25/02)</small>	Service Provider <small>(Doctor Name, Pharmacy, etc.)</small>	Description of Service <small>(Prescription, X-ray, Glasses, etc.)</small>	Amount of Claim
Total Amount						

DEPENDENT CARE FSA SECTION

Dependent's Full Name	Soc. Sec. No.	Date of Birth	Date(s) of Service <small>FROM TO</small>	Service Provider <small>(Soc. Sec. No. or Tax-ID)</small>	Amount of Claim
Total Amount					

Statement by Participant:

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 Plan with respect to such expenses and that such expenses have not been reimbursed, or are not reimbursable, under any other health plan coverage or health care and/or dependent care FSA. 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 the payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which related to such expense. The undersigned further understands that no medical expense tax deduction or dependent care tax credit is permitted for amount for which reimbursement is made.

 Employee Signature Date

Notarial Endorsement for Individual - To be completed by Notary Public only for an employee who is using this form for a recurring Dependent / Elder Care expense for one dependent being cared for by one day care provider.

Provider's Name _____ Federal ID No. _____
 Street Address _____
 City _____ ST _____ Zip Code _____ Phone No. _____
 On this _____ day of _____ before me personally appeared _____ known to me to be the
MONTH AND YEAR EMPLOYEE'S NAME
 person whose name _____ subscribed to the foregoing instrument and acknowledged the same to be _____ free act and deed.
HE / SHE HIS / HER

 Notary Public or Other Official Authorized to Administer Oaths (SEAL)

