Flexible Spending Account Claim Form

Employer Name: ______________________________

Employee Name: ______________________ Social Security #________ - ______ - ________

Mailing Address: ______________________________

Please indicate the amount of your healthcare or dependent care expense(s) below.

HEALTHCARE EXPENSES

Patient's Name	Date(s) of Service	Type of Service (i.e., medical, dental, vision, Rx)	Amount Requested
		TOTAL HEALTHCARE EXPENSES	**$**

DEPENDENT CARE EXPENSES

Patient's Name	Date(s) of Service	Amount Requested
	TOTAL DEPENDENT CARE EXPENSES	**$**

- Always attach a proof of expense (receipt, paid billing statement, or "explanation of benefits" from your insurance company).
- All proofs of expense **MUST** include the date of service.

To the best of my knowledge and belief, my statements in this request for reimbursement are complete and true. I am claiming reimbursement only for eligible expenses. I certify that these expenses have not been and will not be reimbursed under this or any other benefit plan and will not be claimed as an income tax deduction and that these expenses have been incurred during the Plan year for which I am seeking reimbursement.

I authorize reduction of my Flexible Spending Account by the amount of the claim.

Employee Signature: ______________________ **Date:** ______________

Please send this form with proof(s) of expense to:

AmeriBen/IEC Group Flex Administrator

P.O. Box 7186 – Boise, ID 83707 – Toll Free Fax: 800-723-4703 – Email: flex@ameriben.com

If you have any questions for completing this form, please feel free to call our Flex Administrator at 800-786-7930.