

HEALTH CARE FLEXIBLE SPENDING ACCOUNT CLAIM FORM

This claim form is only for requesting reimbursement from your Flexible Spending Account for health care expenses. In order to be reimbursed, a bill, paid receipt or other evidence of payment must be attached to the claim form.

No Reimbursement Will Be Given Unless This Form Is Signed Where Indicated

Employee Name(Please Print)	EMPLID
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Home Address	Number, Street, City, State & Zip Code
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Dependent	Amount	Relationship	Full Time Student?
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Dependent	Amount	Relationship	Full Time Student?
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Dependent	Amount	Relationship	Full Time Student?
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Dependent	Amount	Relationship	Full Time Student?
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RECEIPT FOR HEALTH CARE EXPENSES MUST BE ATTACHED

Total Amount of Reimbursement Requested \$ _____

REMINDER: EXPENSES MUST BE INCURRED AND PAID FOR DURING THE CALENDAR YEAR

I certify that the health expenses being submitted for reimbursement meet the following requirements.

1. The health care expenses were incurred by me or by my eligible members of my family during the period I was a participant in the Health Care Flexible Spending Account Plan. For the purpose of this Plan, medical care expenses have the same meaning as defined in Section 213 of the Internal Revenue Code.
2. The health care expenses not paid by the health care coverage provided through my employer or by any other policies, such as the coverage provided by my spouse's employer. The expenses submitted are either not covered by any other policies or represent amount paid by such policies, such as deductibles or co-payments.

I understand that I am responsible for any tax reporting or other legal requirements with respect to reimbursement expenses. I also understand that to the extent medical care expenses are reimbursed under the Health Care Flexible Spending Account, that may not be claimed as expenses against the Federal income tax credit for medical care expenses.

I authorized the release of any medical information necessary to process this claim. I attest that the expenses for which I am asking reimbursement have actually been, or will be paid by me.

EMPLOYEE SIGNATURE

DATE

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT CLAIM FORM

This claim form is only for requesting reimbursement from your Flexible Spending Account for dependent care expenses. In order to be reimbursed, a bill, paid receipt or other evidence of payment must be attached to the claim form.

No Reimbursement Will Be Given Unless This Form Is Signed Where Indicated

Employee Name (Please Print)	EMPLID
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Home Address	Number, Street, City, State & Zip Code
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Dependent	Amount	Relationship	Full Time Student?
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Dependent	Amount	Relationship	Full Time Student?
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RECEIPT(s) FOR DEPENDENT CARE EXPENSES MUST BE ATTACHED

Total Amount of Reimbursement Requested	\$
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Name and address of Provider

Taxpayer Identification Number or Social Security Number of Provider
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Date of Service	From	To
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Dependent Care Flexible Spending Account

1. The expenses are either for (i) the care of a qualifying individual (e.g., day care center, nursery school or (ii) household services attributable to the care of a qualifying individual. (Educational expenses for a child in the first or higher grades are not eligible)
2. A qualifying individual is (i) a child under age 13, if the child is claimed as a deduction on your Federal Income Tax return: (If divorced or legally separated, the requirement that the child be claimed as a deduction does not apply if you have custody of the child for a longer period of time than the other parent);(ii) your spouse, if your spouse cannot physically or mentally take care of himself or herself;(iii) an individual, such as a parent or child over age 12, who lives with you, who cannot physically or mentally take care of himself or herself, and who can be claimed as a deduction of your Federal Income Tax return (or for whom you could claim such a deduction except that the individual has \$1,950 or more gross income)
3. The expenses are for the purpose of allowing you (and, if married, your spouse) to be gainfully employed during the period you have responsibility for a qualifying individual. Payments made to a child or yours under age 19 or to a person you can claim as a dependent on your Federal Income Tax return are not reimbursable expenses.
4. If married, the amount of reimbursable expenses will not exceed the lesser of your earnings, or yours earning for the year. If your spouse is a full-time student or cannot physically or mentally take care of himself/herself, your spouse is deemed to have earning of \$200 per month (\$400.00 per month if you have at least 2 qualifying individuals).

I certify that the dependent care expenses being submitted for reimbursement meet the aforementioned requirements. I understand that I am responsible for any tax reporting or other legal documents with respect to reimbursement expenses, including name, address and taxpayer identification number of the dependent care provider.

Employee's Signature

Date
