MEDICAL & DEPENDENT CARE FLEXIBLE SPENDING PLAN
APPLICATION FOR REIMBURSEMENT

Employee Information – **Complete all sections.**

Employer Information	Name of Your Employer	
Employee Information	Employee Name	Soc Sec # or BDID (Birth Date: MMDDYYYY and last 4 digits of your Soc Sec #)
	Home Address (complete only if address has changed)	

Section One: Medical Expense (health, dental, vision)-**Proof is required**.

To satisfy requirements for acceptable documentation under your medical reimbursement plan, it is required your documentation includes: Name of service provider, amount owed (after insurance), date of service, nature of service, name of person receiving service.
NOTE: If you have an explanation of benefits statement from your insurance carrier, please submit this as your documentation.
If you are submitting a claim for prescription medication, please provide your prescription tag from your pharmacy. Copies of register receipts do not provide adequate information.

Date of Service Mo./ Day/ Yr.	Name of Person who Received the Service	Description of Expense	Provider of Service	Amount of Expense Claimed
			Total Amount of Medical Expense	$

Section Two: Dependent Care – Independent verification required for the date of service and dollar amount claimed.

Dependent Receiving Care	Dates of Service	Name of Day Care Provider	Amount of Expense
		Total Amount of Dependent Care Expense	$

Daycare Provider Verification:

I certify that the expenses shown are valid.

Signature of Care Provider ____________ Soc. Sec No/Federal Tax Id ____________ Date ____________

Section Three: Employee Certification – **Employee signature required**.

I certify that the above information is correct. I understand that any amounts submitted for dependent care and for which I receive reimbursement cannot also be claimed under the dependent care income tax credit. I understand any medical reimbursements I receive may not be included on my income tax return. I certify that I am requesting reimbursement of medical and/or dependent care expenses which will not be paid or reimbursed under any other plan. I understand that these expenses must qualify for reimbursement under the Internal Revenue Code.

Employee Signature	Date

Please email, mail or fax the completed claim form and appropriate statements to:

ksee@primebenefitsystems.com

or

P.R.I.M.E. Benefit Systems, Inc.
P.O. Box 2239
Cedar Rapids, IA 52406-2239
(319) 294-4046 or (800) 473-8970, ext 4046 PHONE / (319)-395-7498 FAX