CLAIM FSA

EMPLOYEE INFORMATION

Employee Name:		Employee Address:	
Company:			
Last Four Digits of Social Security #:		Has your address changed? Yes: ☐ No: ☐	

DEPENDENT CARE EXPENSES

	Service Start Date mm/dd/yyyy	Service End Date mm/dd/yyyy	Recurring Frequency ex: wkly/mnthly	Service Provider Tax ID# or SS#	Service Provider Name and Address	Dependent's Name	Age	Amount
1.								
2.								
3.								
						Total Dependent Care Expenses Requested		

I provided the dependent care as stated above. If a recurring claim is selected, I attest to providing care for the dates of service provided above.

Provider Signature: _____ Date: _____

HEALTH CARE EXPENSES

Please select a service with each claim.

	Patient	Service Start Date mm/dd/yyyy	Service End Date mm/dd/yyyy	Recurring Frequency ex: wkly/mnthly	Medical	Rx	Dental	Vision	OTC	Mileage $0.16 per mile**	Amount
1.											
2.											
3.											
4.											
5.											
										Total Health Care Expenses Requested	

ORTHODONTIA ONLY *Contract and Proof of Payment Necessary

Banding Date (when appliance were applied):		Recurring Frequency	
For full initial payment, list full cost ($):		*Full Amount eligible for reimbursement*	
For installment plan, list installment amount ($):		*Monthly installment amount eligible upon each due date*	

*Please arrange documentation in order listed above.

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed were incurred during the current period under the company's Cafeteria Plan. The undersigned participant in the Plan understands that expenses are "incurred" when a service is performed or care is provided, not when the bill is paid. The undersigned certifies that all expenses for which reimbursement or payment is claimed on this form were incurred on the dates of service stated above. The undersigned fully understands that he or she is alone fully responsible for the sufficiency, accuracy, and veracity of all the information relating to this claim and unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including Federal, State, or City income tax on amounts paid from the Plan which relate to such expense.

Employee Signature: _____ Date: _____

paylocity