

# Health Care Flexible Spending Account Claim Form

Please submit this claim form to Melissa Bell Brennaman in the Human Resources Office, Building B-3600. Appropriate documentation, such as the Explanation of Benefits from your insurance carrier, proof of co-payment amount from HMO provider, and/or a paid receipt for items not covered by insurance must be attached for reimbursement.

Social Security Number: \_\_\_\_\_  
 Employee Name: \_\_\_\_\_  
 Department: \_\_\_\_\_  
 Insurance Carrier: \_\_\_\_\_

Claim is for:       Self       Dependent

Dependent(s) Name	Date of Birth	Relationship

TOTAL AMOUNT OF REQUEST FOR REIMBURSEMENT \$ \_\_\_\_\_

I certify that:

1. The medical care expenses were incurred by me or by eligible members of my family during the period I was a participant in the Health Care Flexible Spending Account Plan. For the purposes of this Plan, medical care expenses have the same meaning as defined in Section 213 of the Internal Code except for long term medical care costs. These are not reimbursable under the FSA plan.

2. The medical care expenses have not been reimbursed and I will not seek reimbursement in the future under any other plan covering health benefits. I understand that I have the responsibility for any tax reporting or other legal requirements with respect to reimbursed expenses. I acknowledge that I am fully responsible for the accuracy and veracity of all information relating to this claim. If an expense for which I am reimbursed is later disallowed by the Internal Revenue Service, I understand that I will be liable for payment of any related income or payroll taxes relating to such improper expense reimbursement.

3. I also understand that to the extent medical care expenses are reimbursed under the Health Care Flexible Spending Account, they may not be claimed as expenses against the federal income tax credit for medical care expenses.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

## For Accounting Use Only:

Account Balance \_\_\_\_\_ Months Remaining \_\_\_\_\_ \$/Month \_\_\_\_\_

Total Available \_\_\_\_\_ Accounting Department \_\_\_\_\_ Date \_\_\_\_\_

**VID** \_\_\_\_\_ **GRP** \_\_\_\_\_ **VCH** \_\_\_\_\_ **ACCT#** \_\_\_\_\_ **FUND** \_\_\_\_\_