FSA Claim Form

Your Name (Last, First, MI)	Social Security No. or EID	Your Employer Name

Address	City	State	Zip Code

Dependent Care Flexible Spending Account Claims

Payment is allowed only for services **that have already been provided and not for services to be provided in the future.** To substantiate your claim, submit an itemized statement from your provider or **simply have your provider(s) sign below to certify* the care was provided.** If your provider signs below, no other supporting documentation is required.

Name of Dependent	Age	Dates Care Was Provided No Future Dates MM/DD/YY thru MM/DD/YY	① Name/Address of Care Provider or Care Facility ② Type of Dependent Care Service (Daycare, Day Camp, Preschool, After School Care, etc.)		Amount Requested
			①		$
			②		
			①		$
			②		
			①		$
			②		
				Total	$

* Day Care Provider or Care Facility Certification:	* Day Care Provider or Care Facility Certification:
I certify that I provided dependent care services as detailed above. Print Name: _____ Original Signature: _____ Date: _____	**I certify that I provided dependent care services as detailed above.** Print Name: _____ Original Signature: _____ Date: _____

Health Care Flexible Spending Account Claims

Please submit a detailed billing statement or your insurance carrier's Explanation of Benefits (EOB) statement. Paid receipts are not sufficient documentation.

Date(s) of Service	Health Care Provider	Type of Expense (Office Visit, Crown, Eyeglasses, Rx, etc.)	Patient Name	Relationship to You	Amount Requested
					$
					$
					$
					$
					$
					$
				Total	$

I certify that all expenses for which reimbursement or payment is claimed by submission of this form were incurred by me, an eligible spouse, or an eligible dependent during a period while I was covered under my employer's FSA Plan and that the expenses have not been reimbursed and reimbursement will not be sought from any other source. Any claimed Dependent Care expenses are work-related and were provided for my dependent under the age of 13 or for my dependent who is incapable of self care. I understand that I am fully responsible for the accuracy of all information relating to this claim, and that unless an expense for which reimbursement is claimed is a proper expense under the Plan, I may be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan which relate to such expense. A claim will only be processed with a completed and signed claim form and correct documentation.

✔ **Employee Signature** _____ **Date** _____

Fax to: 1.866.686.FLEX (3539)
Page 1 of _____
NO COVER PAGE REQUIRED

Mail to: Flex Made Easy
410 Archibald St, #100
Kansas City, MO 64111

File Online: www.FlexMadeEasy.com
NO CLAIM FORM NEEDED!