

FAX TO: 800-723-4703 (With Receipts) or
 MAIL TO:
 AmeriBen/IEC Group
 P.O. Box 7186
 Boise, ID 83707



FLEXIBLE SPENDING ACCOUNT CLAIM FORM

PLEASE PRINT OR TYPE ALL ITEMS

NAME OF EMPLOYER PINAL COUNTY				DATE OF CLAIM
NAME OF EMPLOYEE FIRST	MI	LAST		EMPLOYEE ID #
ADDRESS: STREET	CITY	STATE	ZIP	DAYTIME TELEPHONE

HEALTH CARE EXPENSE CLAIMS

Person for Whom Expense Incurred and Relationship	Date of Service	Provider of Service	Expense Description	Amount of Claim

Total Health Care Reimbursement Request : \$ _____

**ATTACH COPY OF EACH RECEIPT - MARK RECEIPT WITH EMPLOYEE ALTERNATE ID NUMBER
 A CANCELLED CHECK IS NOT AN ACCEPTABLE FORM OF VERIFICATION
 RETAIN ORIGINAL FOR YOUR RECORDS**

DEPENDENT CARE EXPENSE CLAIMS

(example: Day Care Expenses)

Name of Dependent	Age	Period Covered by Expenses From To	Name and Address of Provider of Service	SS# or EIN Of Provider	Amount of Claim

Total Dependent Care Reimbursement Request : \$ _____

**ATTACH COPY OF EACH RECEIPT - MARK RECEIPT WITH EMPLOYEE ALTERNATE ID NUMBER
 RETAIN ORIGINAL FOR YOUR RECORDS**

STATEMENT OF CLAIM

- ◆ The undersigned participant in the Flexible Spending Account Plan (FSA Plan) certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was a participant in the FSA Plan.
- ◆ The undersigned participant certifies that the medical expenses submitted have not been reimbursed or are not reimbursable under any health plan coverage.
- ◆ The undersigned fully understands that he or she alone is responsible for the sufficiency, accuracy and veracity of all information relating to this claim.
- ◆ The undersigned agrees to provide additional verification of these expenses in the event of an audit by the Internal Revenue Service.
- ◆ The undersigned hereby requests reimbursement for the eligible expenses listed below for the Participant or Participant's eligible dependents
- ◆ The total Dependent Care expenses (if any) for which I am requesting reimbursement this Plan Year do not exceed the lesser of my or my spouse's earned income for the year.

SIGNATURE OF EMPLOYEE

DATE
