



FLEXIBLE SPENDING ACCOUNT CLAIM FORM

Employer Name: _____

Employee Name: _____ SSN: _____ - _____ - _____

Mailing Address: _____ Phone #: _____

Please indicate the amount of your healthcare or dependent care expense(s) below.

HEALTHCARE EXPENSES

Patient's Name	Date(s) of Service	Type of Service (i.e., medical, dental, vision, Rx)	Amount Requested
TOTAL HEALTH CARE EXPENSES			\$

DEPENDENT CARE EXPENSES

Dependent's Name	Date(s) of Service	Type of Service (childcare)	Amount Requested
TOTAL DEPENDENT CARE EXPENSES			\$

- Always attach a proof of expense (receipt, paid billing statement or "explanation of benefits" from your insurance company.
- All proofs of expense MUST include the date of service and patient responsibility.

To the best of my knowledge and belief, my statements in this request for reimbursement are complete and true. I am claiming reimbursement only for eligible expenses. I certify that these expenses have not been and will not be reimbursed under this or any other benefit plan and will not be claimed as an income tax deduction and that these expenses have been incurred during the Plan year for which I am seeking reimbursement in.

I authorize reduction of my Flexible Spending Account by the amount of the Claim.

Employee Signature: _____ Date: _____

Mail, Fax or E-Mail this form with proof (s) of Expense to :
AmeriBen
 P.O. Box 7186, Boise, ID 83707 - Fax – 800-723-4703 – Email – flex@ameriben.com
 Phone: 800-786-7930