

**FLEXIBLE SPENDING ACCOUNT CLAIM FORM**

Request for Reimbursement From **TREE OF LIFE CHRISTIAN SCHOOLS FLEX PLAN**

Employee Name & Social Security Number \_\_\_\_\_

**Instructions for submitting claims.**

**Health Care Expenses**

Please send copies of your health , dental and vision insurance explanation of benefit forms which show what was applied to your deductible, co-pay or rejected. If there is no insurance coverage please submit a itemized invoice. Balance due, balance forward and copies of cancelled checks are not acceptable documentation. For pharmacy claims please submit documentation showing the RX #, date RX was filled and who RX was for, cash register receipts are not acceptable documentation.

**Dependent Care Expenses (Daycare, Pre-school, Latch-key, Day Camp)**

**Documentation should include the following:**

Name and age of the dependent receiving the service

Nature of the services furnished

Name and address, Taxpayer ID or Social Security Number of the supplier of services

Date services were rendered

Amount paid

(Information provided for Dependent Care “Contract” must be provided at each plan renewal)

Type of Expense MED or DEP	Date Incurred	Provider	Amount
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
Total			\$ _____

I request payment from the Flexible Spending Account for the expenses itemized above. I certify that I or my spouse have not requested reimbursement under this Plan or from any other source for these expenses and that these expenses are not reimbursable under any other plan. I also certify that 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. I further certify that I have met all of the requirements for eligible health care and dependent care expenses. I understand that expenses reimbursed under the FSA cannot be claimed on my personal income tax return and must be deducted for purposes of my dependent care tax credit calculation, if claimed, and, when added to expenses already reimbursed in this year, will not exceed the amount to which I or my spouse are entitled.

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

\_\_\_\_\_  
Date

**Attach all required documentation and Mail to:**

**Benefits Plus, Inc.  
Attn: Claims Administration  
P.O. Box 606  
Connersville, IN 47331-0606**

**Phone 1-800-825-3539**

**PLEASE COPY THIS FORM FOR FUTURE CLAIM SUBMISSIONS**