FLEXIBLE SPENDING ACCOUNT
REIMBURSEMENT REQUEST FORM (CLAIM FORM)
(THIS FORM IS USED TO FILE FOR REIMBURSEMENT WHEN FLEX CARD IS NOT USED)

Instructions: Please print or type and complete all items under **Personal Information**. In order to receive reimbursement, you must submit an *Explanation of Benefits Statement* (if applicable) from your insurance carrier or an itemized statement that includes the provider name, patient name, date of service, description of service, insurance responsibility (if applicable), and patient responsibility for each health care claim. For dependent care reimbursement you may either: (1) Fill out all items in the **Dependent Care Expenses** section and attach a receipt of your payment **OR** (2) Fill in your dependent's name, age, date of service and the requested amount, and have your Day Care provider fill out the **Affidavit of Dependent Care Provider**. Be sure to sign and date this form. You may photocopy this form.

Company/Employer Name	
Employee's Name:	**E-Mail Address:**
Employee's Last 4 digits of SSN or Employee Number:	**Daytime Telephone #:**

UNREIMBURSED MEDICAL EXPENSES

Patient Name	Relationship	Age	Date of Service	Type of Service (Medical, Dental, etc.)	Amount Requested
1.					
2.					
3.					
4.					
5.					
6.					
				Total	

DEPENDENT CARE EXPENSES

Name(s) of Dependent	Age	Date(s) of Service		Amount Requested
		From	To	
1.				
2.				
3.				
			Total	

AFFIDAVIT OF DEPENDENT CARE PROVIDER

I have provided adult/child care for ____, age _______, for the period

beginning ________________ and ending _______________________.

Services were provided by ____ for a fee of $_____________.

X ______________________________ ________________________ _________________________

Signature of Provider **Tax ID# or Social Security #** **Date**

I, the undersigned, hereby certify that the above listed expenses are for myself or a Federal tax-qualified dependent and have not been previously reimbursed from my Flexible Spending Account, nor are reimbursable from any other source. I hereby authorize Stanley Benefit Services to obtain necessary information from all physicians, hospitals, daycare providers, employers and all other agents in order to adjudicate the claim for reimbursement under the Benefit Plan established by my employer.

______________________________________ ______________________

Employee's Signature **Date**

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