FLEXIBLE BENEFIT PLAN SPENDING ACCOUNT CLAIM FORM

Employee Information (*Please Print*)

Employee Name: ______________________ Employee ID # ______________

Company Name: ______________________ Day Phone # ______________

Plan Year: ______________________ E-Mail

Description of Expenses and Claim Amounts Requested

Enter each expense on a separate line and attach any necessary copies of receipts to this form.

DEPENDENT CARE EXPENSES:

Dependent Name	Types of Service	Dates of Service From	To	Claim Amount
Total Dependent Care Claim Submitted				$______________

Dependent Care Provider FEIN or SS #: ______________________

Dependent Care Provider Signature: ______________________ Date Care Provider signed:

HEALTH CARE EXPENSES [Medical, Dental, and/or Vision]:

Dependent Name	Relationship	Types of Service	Dates of Service From	To	Claim Amount
Total Health Care Claim Submitted					$

EMPLOYEE'S CERTIFICATION OF REIMBURSEMENT REQUEST

I certify that I incurred the expenses requested for reimbursement from my Flexible Benefit Plan Spending Account(s). The expense(s) have been incurred and **will not be reimbursed by any other insurance or company plan**. To the best of my knowledge and belief, they are eligible for reimbursement under my Flexible Benefit Plan. I will not use the expenses reimbursed through the Flexible Benefit Plan as a credit or a deduction when filing my income tax return.

Any person who knowingly and with intent to injure, defraud or deceive any qualified plan, files a statement of claim containing false or incomplete information may be guilty of a criminal act punishable under the law.

Health Insurance Portability and Accountability Act (HIPAA)

Under HIPAA regulations you are assured that certain health information, referred to as Protected Health Information (PHI), will be kept confidential. Disclosure of your PHI for any purpose other than for "Plan Administration" such as quality assurance, claims processing, auditing and monitoring or for the purpose of obtaining payment will be limited and subject to state and federal regulations. To learn more about these Privacy Rules contact your Flexible Benefit Plan Coordinator to receive a complete Notice of Privacy Practices.

Employee Signature________________________________ Date__________________

INTERNAL USE ONLY	Claim Review By: ______________	Claim Entry Date: ____________

Return Claim Form and Documentation to: **Fax to**: 303-649-1925 or 800-889-6260
Mail to: 6450 S Quebec Street, Suite 5-28, Centennial, Colorado 80111
E-mail to: claims@flexmagic.com Questions: 303-649-1922 or 800-888-9084 www.flexmagic.com