Medical & Dependent Care Flexible Spending Plan
Application for Reimbursement

Employee Information – Complete all sections

Employee Name:	Soc Sec # or BDID (Birth Date:MMDDYYYY & last four digits of your social security #)

Home Address (if changed)

Section One: Medical Expense(s) – Proof is required

To satisfy requirements for acceptable documentation under your medical reimbursement plan, it is required your documentation includes: Name of service provider, amount owed (after insurance), date of service, nature of service, name of person receiving service. If you have an explanation of benefits (EOB) statement from your insurance carrier, please submit this as your documentation. If you are submitting a prescription claim, please provide your prescription tag from your pharmacy. Copies of register receipts do not provide adequate information.

Date of Service Month/Day/Year	Name of who received the service	Description of Expense	Provider	Amount of Expense
			Total Amount of Medical Expenses	$

Section Two: Dependent Care – Independent verification required for date of service and dollar amount claimed.

Dependent Receiving Care	Dates of Service	Name of Provider	Amount of Expense
		Total Amount of Dependent Care Expenses	$
Daycare Provider Verification	Signature	Soc. Sec No/Federal Tax ID	Date

Section Three: Employee Certification – Employee Signature Required

I certify that the above information is correct. I understand that any amounts submitted for dependent care and for which I receive reimbursement cannot also be claimed under the dependent care income tax credit. I understand any medical reimbursements that I receive may not be included on my income tax return. I certify that I am requesting reimbursement of medical and/or dependent care expenses which will not be paid or reimbursed under any other plan. I understand that these expenses must qualify for reimbursement under the Internal Revenue Code.

Employee Signature	Date

Please email, mail or fax the completed claim form and appropriate statements to:

ksee@primebenefitsystems.com

P.R.I.M.E Benefit Systems, Inc.
P.O. Box 2239
Cedar Rapids, IA 52406
Phone: (319) 294-4046 l Fax: (319) 395-7498