

# Flexible Benefit Plan Reimbursement Claim Form

Please fax completed forms and all associated documentation to:  
618-654-4624  
or mail your claim to:  
Qualified Plan Services, Ltd.  
1000 Broadway, Suite 300  
Highland, IL 62249

Employer:

Click to CLEAR all fields:

Employee Name:

Social Security Number:

Address:

Phone:

E-mail:

## Dependent Care Expense Claims

Name of Dependents	Period Covered		Name, Address, and Taxpayer Identification Number of Service Provider	Amount Incurred
	From	To		
<p>➔ <i>Attach a receipt from your daycare provider, or include the daycare provider's signature.</i></p>			<p><b>Provider's Signature:</b></p>	
<p style="text-align: right;"><b>Total Dependent Care Expense Claim*</b></p>			<p style="text-align: right;"><b>\$</b></p>	

\*NOTE: The total amount claimed under the Plan for any coverage period must not exceed the lesser of your earned income for the Plan Year or the earned income of your spouse. (If your spouse is either a full-time student or is incapable of taking care of himself or herself, then he or she is deemed to have monthly earnings of \$200 if there is one (1) child or dependent, or \$400 if there are two (2) or more.) No payment may be made under the Plan; if the service provider is your dependent for federal income tax purposes; or is your child or stepchild and is under age 19.

## Unreimbursed Medical Expense Claims

Date Expense Incurred	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount
<p>➔ <i>Attach appropriate receipt(s) and submit with this claim form.</i></p>			<p style="text-align: right;"><b>Total Medical Care Expense Claim</b></p>	<p style="text-align: right;"><b>\$</b></p>

**Read Carefully:** The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the Company's Cafeteria Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date