Flexible Benefit Plan Claim Form

ACCOUNT HOLDER INFORMATION:
Name of Employer:
Employee Name:
Social Security Number:
Day Time Phone Number:

Please reimburse the following Medical and/or Dependent Care expenses as covered under the Flexible Spending Account Plan.

Dependent Care Flexible Spending Account Claims:

Name of Dependent(s)	*Period Covered*	*Name, Address, & Tax ID Number*	*Amount*

Total Dependent Care Claim $

Flexible Spending Accounts:

Date Expense Incurred	*Name of Service Provider*	*Person For Whom Expense Incurred*	*Expense Description*	*Amount*

Total Medical Claim $

A detailed receipt including the merchants name, date of purchase, product name and the amount paid for the item must accompany any claim.

- You are responsible for determining the validity of each item to be reimbursed; it is not the responsibility of your Employer or the administration company.
- These items cannot be reimbursed under any other plan.
- Supporting documentation must be attached to validate all reimbursement requests.
- Documentation must be a copy of the bill, explanation of benefits (EOB) or receipt which provides date of service or date of purchase.
- For Over The Counter (OTC) expenses to be reimbursed you must submit a detailed receipt including the merchants name, date of purchase, product name and the amount paid for the item.
- Medical Care Expenses reimbursed by this Plan cannot be claimed as deductions on your personal income tax return.
- Child Care Expenses cannot be reimbursed in excess of $5,000 per year. Child care expenses reimbursed by this Plan cannot be claimed as a credit on your personal income tax return.

Employee's Signature: X _____ **Date:** _____

Fax to: 216-642-4863

Mail to: Vantage Financial Group Flexible Benefits 6200 Rockside Road, Suite 100 P.O. Box 318082 Cleveland, OH 44131