Flexible Benefit Plan
Reimbursement Claim Form

To complete this claim form:

- Move through the fields on this form by pressing the Tab key.

Employer: Page of

Employee Name: Social Security Number:

Phone: E-mail:

Dependent Care Expense Claims

Name of Dependents	Period Covered From	To	Name, Address, and Taxpayer Identification Number of Service Provider	Amount Incurred
➔ *Attach a receipt from your daycare provider, or include the daycare provider's signature.*			**Provider's Signature:**	
			Total Dependent Care Expense Claim*	$0.00

*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 $250 if there is one (1) child or dependent, or $500 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 (mm/dd/yy)	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount
➔ *Attach appropriate receipt(s) and submit with this claim form.*			**Total Medical Care Expense Claim**	$0.00

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 _____

Custom Benefit Services, Inc.

PO Box 4078 · Ocala, FL 34478
Phone: 352-369-9453 / 800-809-8161 · Fax: 352-369-9461

Flexible Benefit Plan

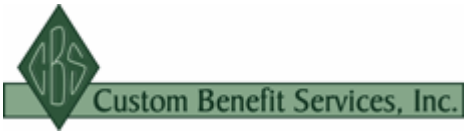
Claim Form & Filing Instructions

On the reverse side of this page is a claim form. Please feel free to copy this form.

When filing your claim, you must attach copies of the receipts. **The receipt must show the date and type of service for the expense.** Canceled checks, credit card slips, or statements showing only a balance due on your account are not allowable. Please be sure to number each attachment page (i.e., Page 2 of 3, Page 3 of 3, etc.).

If you choose to **mail** your claim with receipts, the address is Custom Benefit Services, Inc., PO Box 4078, Ocala, FL 34478. (*Please remember to keep a copy of the claim form and supporting documents for your records.*)

If you choose to **fax** your claim with receipts, the fax number is 352-369-9461. After you fax a claim and receipts, please ***do not*** follow-up with a hard copy in the mail. (*Remember to keep the original claim form and supporting documents for your records.*)



Copy the front and back of this claim form for future use
