FlexSave™
Flexible Spending Program

Flexible Benefit Plan Reimbursement Claim Form

Customer Service – 800.525.9252
Weekdays 8 a.m – 5 p.m. EST

Employer: _____

Employee Name: _____

Phone: _____

(You may copy this claim form for future use)

Claim Submission Information:
Fax Claim Form and Receipts to: 440.878.4890
Or Mail to:

FlexSave
MZ: 04-2W-8317
2060 East Ninth Street
Cleveland, OH 44115-1355

Dependent Care Expense Claims

Name of Dependents	Period Covered From	To	Name, Address, and Taxpayer Identification Number of Service Provider	Amount Incurred
			Total Dependent Care Expense Claims*	**$**

Dependent Care Provider Certification (Necessary only if receipt is not provided)**:** I certify that the services for the above noted service period(s) and cost(s) have been incurred by the claimant and that I have not previously certified these expenses.

Dependent Care Provider's Signature:_____ **Date** _____

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 Unreimbursed Medical Expense Claims***		**$**

***CERTIFICATION AND AUTHORIZATION**

I certify that the information on this form is accurate and complete. I am requesting reimbursement for eligible expenses incurred by myself or an eligible dependent while I was a participant in the plan. I have already received these products and services and have not been previously reimbursed for these expenses and I will not seek reimbursement of these expenses from any other plan or party. In addition, the expenses for which reimbursement is sought will not be claimed as tax deductions on my personal tax return. I understand that if an expense is determined to be ineligible, I am responsible for reimbursing the plan(s) for any such expense or for payment of all related income taxes on amounts paid from the plan(s) which relate to such expense. If I am covered under more than one health care account, reimbursement will be made according to the payment order determined by those plans. I also certify that if I am requesting reimbursement for work-related dependent care expenses incurred for care provided by a valid dependent care provider to an eligible dependent (for children under the age of 13 or other dependents that are physically or mentally incapable of taking care of themselves) it was while I was a participant in the plan.

_____ _____

Employee's Signature **Date**