

KLAIS & COMPANY, INC.

EMPLOYEE BENEFIT CONSULTANTS AND ADMINISTRATORS

1867 WEST MARKET STREET

AKRON, OHIO 44313-6977

(330) 867-8443

1-800-331-1096

STATEMENT OF CLAIM FOR FLEXIBLE BENEFITS ACCOUNT

I. GENERAL INFORMATION - COMPLETE ALL INFORMATION AS REQUESTED.

Your Employer _____ Soc. Sec. # _____

Your Name _____ Home Phone _____ Work Phone _____

Home Address _____
Street City State Zip

II. FOLLOW THE DIRECTIONS BELOW FOR HEALTH CARE REIMBURSEMENT ACCOUNT CLAIMS

If you have health care expenses which you submitted to your group health plan which were not reimbursed due to deductibles, co-insurance or reasonable and customary provisions, simply attach a copy of the Explanation of Benefits (EOB) form.

If you have health care expenses which are not covered by your group health plan, attach your **original** receipts. Receipts must contain the following information in order to be considered:

1. Date of Service
2. Type of Expense
3. Name of the Provider of Service or Product
4. Name of Person receiving Service or Product
5. Amount of Expense

III. FOLLOW THE DIRECTIONS BELOW FOR DEPENDENT CARE REIMBURSEMENT ACCOUNT CLAIMS

List the names and ages of all dependents you are filing a claim for below:

Name of Dependent	Age
_____	_____
_____	_____
_____	_____

If you have day care expenses for children under 13 years of age, or for disabled parents, spouses or children who qualify as a dependent on your federal tax return, attach your **original** receipts. Receipts must contain the following information in order to be considered:

1. Date of Service
2. Type of Expense (i.e. Childcare, Eldercare, etc.)
3. Name of the Provider of Service
4. Address of Provider of Service
5. Provider's Tax ID# or Social Security#
6. Amount of Expense

IV. EMPLOYEE CERTIFICATION - READ AND SIGN THIS SECTION

I certify that the information accompanying this form is for true and correct health care or dependent care expenses on myself or my legal dependents. I understand that any expenses reimbursed from this account are not tax deductible on my Federal Income Tax Return. I certify that these expenses have not been paid, and are not payable, under any other group benefit plan.

Date: _____ 20____ Signature of Employee _____