

Section 125 Cafeteria Plans Claim Form - DCAP & FSA

Date: _____
Fax- # of Pages: _____

Personal Information

Employee Name: _____ SSN: _____ Email: _____

Employer Name: _____ Date: _____

Dependent Care Assistance Plan (DCAP) Claim Information

Dependent Name	Service Date (From mm/dd/yy - To mm/dd/yy)	Daycare Provider (Include name, address & taxpayer ID #)	Cost of Service
_____	_____ - _____	_____	\$ _____

_____	_____ - _____	_____	\$ _____
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Total \$ _____

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/herself, then he/she is deemed to have monthly earning of \$200 if there is [1] child/dependent, and \$100 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/stepchild and is under age 19.

Flexible Spending Account (FSA) Claim Information

Name of Person Incurring Service	Service Date	Service Provider Name	Service Description	Reimbursement Amount
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____

Total \$ _____

FSA Claims: Valid service receipt(s) MUST be included with your claim reimbursement form. Valid service receipts must contain the following to be processed: patient name, provider information, date of service (fill date for prescription), service description (office visit, prescription drug name, etc.) and cost. Explanation of benefit (EOB) statements must be submitted for hospital and/or surgical expenses. Prescription drug ID tags must be submitted for prescription drug expenses.

Acknowledgement and Signature

Read Carefully: The undersigned participant of the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the Company's Flexible Spending Account (FSA) with respect to such expenses and that 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. I authorize release of payment through my FSA.

I authorize eBenefits Administrators, Inc., or its representatives, to obtain necessary information from all physicians, hospitals, medical service providers, pharmacists, employers and all other agencies or organizations (including other insurers) to consider the claim for reimbursement under my benefit account(s). Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature: _____ Date: _____