Flexible Benefit Plan
Reimbursement Claim Form

Employer: _____ **Employee SSN Last 4 digits:** XXX-XX-_____

Employee: _____

Phone: _____ **E-mail:** _____

Dependent Care Expense Claims

Name of Dependents	Period Covered From	Period Covered 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*	$

*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 $200 if there is one (1) child or dependent, or $400 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**		$

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 Signature

_____ Date

***Note: Form must be signed in order to process the claim.**

Claim Filing Procedures...

How To File A Claim

- Complete **all** information on the claim form for each amount claimed for reimbursement.
- Make sure the claim does not include items for more than one plan year. Use different claim forms for different years.
- You must sign and date the claim form.
- Attach a copy of a bill, invoice or other written statement from a third party which supports each reimbursement request and shows the date the service was incurred.
- Statements showing only a balance forward and copies of cancelled checks or credit card receipts are ***not*** valid receipts.

Claim Form

If you **mail** your claim with receipts, remember to keep a copy of the claim form and supporting documents for your records.

If you **fax** your claim with receipts, please remember to keep the original claim form and supporting documents for your records.

Where To Send A Claim

Mailing Address: Davevic Benefit Consultants, Inc.
902 South Center Street
P. O. Box 976
Grove City, PA 16127

Fax: 724-458-4464

E-mail Attachment: flexcontact@davevic.com

Phone: 724-458-7255 or toll free 800-854-4099

Online Account Access: www.davevic.com