Flexible Benefit Reimbursement Claim Form

1. Employee Information: Complete all sections.

Employer Information	Name of Your Employer			
Employee Information Check box if new address. ☐	Employee's Last Name	First Name	Initial	Employee's Social Security Number / /
	Home Address		E-mail Address	
	City	State	Zip	Daytime Phone Number

2. Health Care: An itemized statement is required including date of service, type of service, and total charge.

Please check <u>one</u> of the following boxes:

☐ Charges attached are partially covered benefits under my health and/or dental insurance coverage. Enclosed is an Explanation of Benefits from my insurance. An Explanation of Benefits is required even if charges are applied to your deductible or out-of-pocket liability.

☐ Charges are **not** a covered benefit by any insurance plan for which the patient is enrolled.

☐ Charges attached are for reimbursement of my office visit or prescription drug co-pay due at the time of service. My insurance company does not provide an Explanation of Benefits for these services. Enclosed is an itemized receipt provided by the provider of service.

Date(s) Incurred	Name of Person Receiving Care	Date of Birth	Description of Expense	Provider Name (e.g., clinic, doctor, hospital)	Total Expense	Amount Paid by Insurance	Amount Remaining
					$	$	$
					$	$	$
					$	$	$
					$	$	$
				TOTAL AMOUNT OF MEDICAL EXPENSE	$	$	$

3. Dependent Care: A receipt is required from your daycare provider that includes dates of care and total charge. If you do not have a receipt, the daycare provider must sign verification section.

Dependent Receiving Care Name	Relationship	DOB	Date(s) of Care	Daycare Provider (Name and Soc. Sec. No./Federal Tax ID)	Amount

DAYCARE PROVIDER VERIFICATION: I certify that the expenses shown are valid.

_____ Daycare Provider Signature

_____ Social Security Number / Federal Tax ID

_____ Date

4. Employee Certification: Employee signature required.

I certify that the above information is correct. I understand that any amounts submitted for dependent care and for which I received reimbursement cannot also be claimed under the dependent care income tax credit. I understand any medical reimbursements I receive may not be included on my income tax return. I certify that I am requesting reimbursement of medical and/or dependent care expenses, which will not be paid or reimbursed under any other plan. I understand that these expenses must qualify for reimbursement under the Internal Revenue Code.

Employee's Signature: _____ **Date:** _____

Please send the completed claim form and appropriate statements to:

TRISTAR Benefit Administrators
PO Box 65887
West Des Moines, IA 50265
800-456-4584
Fax: 515-453-2354
Email: flex@tristargroup.net