

Please Staple  
Receipts Here



# CLAIM FORM



## FLEXIBLE SPENDING ACCOUNT REIMBURSEMENT REQUEST

**\$50.00 minimum reimbursement for paper check. Any claims received under \$50.00 will be returned except for last check of the year. Does not apply to direct deposit.**

Your Company's Name: \_\_\_\_\_  
 Your Name \_\_\_\_\_  
 Are you still employed at the above Company?  Yes  No If no, what date did you terminate employment? \_\_\_\_\_  
 Is this your first claim this year?  Yes  No Have you moved since your last claim or since you enrolled? \_\_\_\_\_  
 Email Address \_\_\_\_\_ If so, tell us where: \_\_\_\_\_  
 Day Time Phone \_\_\_\_\_ Street Address: \_\_\_\_\_  
 City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip \_\_\_\_\_

### **DEPENDENT CARE** (Child Care or Elder Care): Complete only if you elected this on your initial enrollment form.

Provider Name	Provider SS# or Tax ID#	Dependent's Age	Services Rendered	Claim Period From	To	Date Paid	Amount

**If you do not have a receipt for Dependent Care expenses you are claiming, you must have your Dependent Care provider complete and sign this section:**

Provider's Name: \_\_\_\_\_  
 Provider's Address: \_\_\_\_\_  
 Provider's SS# or Tax ID #: \_\_\_\_\_  
 I certify that I have provided the services listed above:  
 \_\_\_\_\_  
 Provider's Signature \_\_\_\_\_ Date \_\_\_\_\_

### **NON-REIMBURSED MEDICAL EXPENSES:** Complete only if you elected this on your initial enrollment form.

Provider Name	Service Rendered/Item Purchased	Service was for (Name/Relation)	Date of Service*	Amount

\*MUST BE DATE THE SERVICE WAS RECEIVED, NOT WHEN BILL PAID (If more lines required, use back of form)

**NOTE: CLAIMS WITH INCOMPLETE OR MISSING INFORMATION OR MISSING RECEIPTS WILL BE RETURNED TO THE SENDER**

#### READ CAREFULLY

I request reimbursement for my dependent care and/or non-reimbursed medical expenses as itemized above. Attached are receipts which provide: date of service, provider name, type of service, for whom the service was provided, and fee charged. These expenses are not eligible for reimbursement from any other source. I understand that these expenses must qualify for reimbursement under the Internal Revenue Code and that they cannot be claimed as credits or expenses on my personal income tax return.

I have retained copies of the receipts and documentation attached with this request. I understand that materials submitted will not be returned to me. **Concepts In Benefits, Inc. does not retain materials after a request is processed.**

YOUR SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

***Fax, mail or email this form with receipts to:***

Concepts in Benefits, Inc., 43 Constitution Drive, Bedford, NH 03110

Form and receipts may be faxed to: (603) 472-3281 or emailed: [cbi@conceptsinbenefits.com](mailto:cbi@conceptsinbenefits.com)