



Flexible Benefit Plan Claim Form

FAILURE TO COMPLETE THIS FORM IN FULL MAY DELAY PAYMENT
Please consult your Employee Handbook or contact your Plan Service Provider to be sure your expense is eligible for reimbursement.

ClaimForm

SECTION A – EMPLOYEE DATA (PLEASE PRINT)

Name of Employer: (must complete): _____

SSN: _____	Name: _____	Daytime Phone: _____
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SECTION B – CLAIM ENTRY- PLEASE BE SURE ALL INFORMATION IS ENTERED.

Miscellaneous Health	1. Attach copy of Explanation of Benefits (EOB's) for deductible and coinsurance reimbursement requests. 2. Attach itemized bills for expenses not covered by medical/dental insurance. Itemized bills must include the date of service, provider's name, services provided, "condition being treated" and amount of expense. 3. Balance Forward Statements, Canceled Checks And Credit Card Receipts Are Not Acceptable. If you used your mySourceCard to purchase these items, please let us know						
	Provider / Vendor Amount	mySourceCard	Name of dependent who incurred the expense	Date(s) of Service	Insurance Coverage	Requested	
	_____	YES NO	_____	_____	YES NO	\$ _____	
	_____	YES NO	_____	_____	YES NO	\$ _____	
	_____	YES NO	_____	_____	YES NO	\$ _____	
If you need additional space to list expenses please use the back of this sheet.						TOTAL	\$ _____

Dependent Daycare	Proof of expense must include dates of service, provider's name, amount of expense and provider's tax identification number (T.I.N) or social security number. If no receipt is available, complete the claim form and have your provider sign where indicated.				
	Dependent Care Provider	Name of dependent of whom expense incurred	Date(s) of Service From / To	SSN / TIN	Requested Amount
	_____	_____	_____/_____/_____	_____	\$ _____
	_____	_____	_____/_____/_____	_____	\$ _____
Provider Signature: _____				TOTAL	\$ _____

SECTION C - DISCLOSURE. PLEASE READ AND SIGN BELOW

I certify the above expenses qualify for reimbursement under the terms of the Flexible Benefit Plan. I specifically state that the expenses listed have been incurred for the benefit of me and/or my eligible dependents. I have attached acceptable proof of expense to this form. I certify that the above is correct and complete and that all out-of-pocket expenses reimbursed to me under this program will not be deducted on my, or my spouse's personal tax return or be reimbursed to me or my dependents by any other means.

Date: _____	Employee Signature: _____
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Attach proof of expense and send completed form to:
BENEFIT DYNAMICS - a division of Pension Dynamics Corporation
*2300 Contra Costa Blvd., Suite 400 Pleasant Hill, CA 94523-3955
*Main (925)-956-0514 *Fax 866-320-1931
Benefits@PensionDynamics.com