AMERIFLEX

# SPENDING ACCOUNT CLAIM FORM

☐ Designate the number of pages included in transmission when using this form as a fax cover page.

Employee Name: _____

Company Employed By: _____

Employee Social Security # _____-_____-_____ Employee Phone #: _____-_____-_____

## Medical Expense (MFSA)

Please attach/enclose appropriate proof of eligible medical expense. The itemized receipt should list: date of service, paid charges, and service provided. IRS Ruling – We can **not** accept credit card receipts/statements as eligible proof of expense.

| Date(s) of Service(s): | Type of Expense(s): | Requested Amount: |
|---|---|---|
| _____ | _____ | $_____ |

## Dependent Care Expense (DCSA)

Please attach/enclose receipt or statement from daycare provider listing: name/tax id# of provider, name of child, and date of service. Dependent care is reimbursed after service is provided, not when the bill is paid.

| Date(s) of Service(s) From – To: | Tax ID# of Daycare Provider: | Name of Child(ren): | Requested Amount: |
|---|---|---|---|
| _____ | _____ | _____<br>_____ | $_____ |

## Healthcare Expense (HRA)

Please attach/enclose appropriate proof of eligible medical expense. The itemized receipt should list: date of service, paid charges, and service provided. IRS Ruling – We can **not** accept credit card receipts/statements as eligible proof of expense.

| Date(s) of Service(s): | Type(s) of Expense: | Requested Amount: |
|---|---|---|
| _____ | _____ | $_____ |

## Transit Expense (CRA)

Date(s) of Service(s): _____ TOTAL Requested Amount: $ _____

## Parking Expense (CRA)

Date(s) of Service(s): _____ TOTAL Requested Amount: $ _____

To the best of my knowledge and belief, my statements on this claim form are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants. I certify that these have not been previously reimbursed on this or any other benefit plan, will not be reimbursed elsewhere, and will not be claimed as an income tax deduction. I authorize my account(s) to be reduced by the amount requested. To avoid delays in reimbursement, please sign and date this claim form and provide notice of any name or address change. When faxing, use this form as a fax cover page.

Employee Signature: _____ Date: _____

**Mail:** 303 Fellowship Road, Mount Laurel, NJ 08054 **Fax:** 856-631-1020 Attention: Claims Department
Attention: Claims Department

**Please allow 2–3 weeks for check delivery. To receive direct deposit for reimbursements, please visit our website at www.flex125.com and complete an employee direct deposit form. Please allow 5–7 business days for Direct Deposit.**