

PAYROLLING.COM
FLEXIBLE SPENDING ACCOUNT CLAIM FORM

Payrolling.com

Employee Name (Last, First, M.)

Social Security Number

Employer

Street Address

City

State

Zip Code

Check if new address

I. MEDICAL CARE EXPENSES: (Eligible expenses not paid by any insurance.) Attach an itemized bill showing the following information and a copy of the Explanation of Benefits from your insurance company showing their payment or denial. Cancelled checks or balance due receipts are not acceptable.

Date of Service	Patient Name	Relationship to Employee	Provider Name	Description of Services	Amount Requested
TOTAL:					

II. DEPENDENT CARE EXPENSES: (Attach receipts or have your provider sign and complete the following.) **The IRS requires the dependent care provider to furnish the provider's current name, address, tax ID number (or SSN) to the taxpayer making the claim.** unless the provider is exempt from federal tax income taxation as described in I.R.C. Section 501(C)(3).

The Dependent Care Information including provider name, address, TIN/SSN is correct to the best of my knowledge. I understand that I may incur penalties of perjury if the information is knowingly misstated. (Signed below by Provider).

Dates of Care (From:To)	Dependent Name	Age	Print Provider Name	Provider Address	TIN/SSN	Amount Requested
			Provider Signature			
TOTAL:						

The undersigned participant certifies that all expenses for which reimbursement of payment is claimed were incurred during a period while the undersigned was covered under the Plan and were not reimbursed from any other source. The undersigned fully understands that he/she is fully responsible for the accuracy of all information relating to this claim. The undersigned may be liable for payment of Federal, State and City income tax on amounts paid from the Plan which are not eligible expenses.

Employee Signature: _____ Date: _____