

Flexible Benefit Plan Reimbursement Claim Form

(Do not use for flex debit card expenses)

Kabel Business Services
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 Phone 515-224-9400 Fax: 515-224-9256
 For account inquiries and additional forms
 visit our web site at www.kabelbiz.com.
 Email: claims@kabelbiz.com

Employer:	
Employee Name:	Social Security Number:
New Address:	Phone:

Dependent Care Expense Claims

Name of Dependent	Period Covered From To	Name & Address of Service Provider	Amount Incurred
<i>Ⓟ Attach a receipt from your daycare provider, or include the daycare provider's signature</i>			Provider's Signature:
Total Dependent Care Expense Claim*			\$

*NOTE: The total amount claimed under the Plan for any coverage period must not exceed the lesser of your earned income for the Plan Year or the earned income of your spouse. (If your spouse is either a full-time student or is incapable of taking care of himself or herself, then he or she is deemed to have monthly earnings of \$200 if there is one (1) child or dependent, or \$400 if there are two (2) or more.) No payment may be made under the Plan if the service provider is your dependent for federal income tax purposes, or is your child or stepchild and is under age 19.

Unreimbursed Medical Expense Claims

Date Expense Incurred (mm/dd/yy)	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Amount Incurred
<i>Ⓟ Attach appropriate receipt(s) and submit with this claim form.</i>			Total Medical Care Expense Claim	\$

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Individual Insurance Premiums

Name of Insurance Provider	Insured's Name	Type of Insurance (i.e. Medical, Dental, etc.)	Date(s) of Service Coverage	Amount Incurred
<i>Ⓟ Attach appropriate receipt(s) and submit with this claim form.</i>			Total Insurance Premium Expense Claim	\$

Read Carefully: I authorize the above expenses to be reimbursed from my Health FSA Account. To the best of my knowledge, my statements on the Form are true and complete. I certify all of the following: Either I, my Spouse or my Dependent has received the services described above on the dates indicated, and the expenses qualify as valid Medical Care Expenses under Code 213 (d), as further defined in the Health FSA Plan document (the "Plan"). These Expenses have not previously been submitted for reimbursement under the Plan. They have not been reimbursed under this Plan or any other Plan, and I will not seek reimbursement for them under the major medical plan or any other health plan. These expenses are for medical care excluding cosmetic purposes, are not incurred for general health purposes and do not constitute toiletries. I understand that the expenses reimbursed may not be used to claim any federal income tax deduction or credit. I also understand that I may be asked to provide further details about some expenses (e.g., a statement from a medical practitioner that the expense is to treat a specific medical condition or a more detailed certification from me).

Employee Signature _____ Date _____

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