

StLL Flex Claim Form

Medical & Dental Reimbursement Account
 Dependent Care Reimbursement Account
 Premium Reimbursement Account

Fill out the following information:

School District: _____

Employee Name: _____

Employee Social Security Number: _____

Employee Phone Number: _____

Employee Address: _____
(Street)

 (City) (State) (Zip)

(Please check here if address has changed)

	Date(s) of Service	Amount	Description of Service	Provider of Service <small>If for Dependent Care Reimbursement fill in provider=s SS # (babysitter) or Tax ID # (day care centers) - Must Be Completed</small>	Claimant Name	Relationship to Employee <small>(i.e. Self/Spouse/Child/Other-Must Specify)</small>
<input type="checkbox"/> Med/Dent <input type="checkbox"/> Dep Care <input type="checkbox"/> Premium						
<input type="checkbox"/> Med/Dent <input type="checkbox"/> Dep Care <input type="checkbox"/> Premium						
<input type="checkbox"/> Med/Dent <input type="checkbox"/> Dep Care <input type="checkbox"/> Premium						
<input type="checkbox"/> Med/Dent <input type="checkbox"/> Dep. Care <input type="checkbox"/> Premium						

I certify that the expenses for which reimbursement is being requested have been incurred for myself, my spouse, and/or my dependents. Any medical and/or dental expenses for which I am requesting reimbursement are expenses, which have not been reimbursed and are not reimbursable under any other health plan coverage. Any dependent day care expenses for which I am requesting reimbursement are expenses, which have not been reimbursed and are not reimbursable under any other program. I understand that I must provide the taxpayer identification number of the dependent day care provider on my federal income tax return if I am requesting reimbursement of dependent day care expenses, and I will comply with this requirement. My spouse is not claiming reimbursement for the dependent care expenses under any coverage provider by his/her employer.

 (Signature)

 (Date)