GROUP NAME :
Health Care or Dependent Care Flexible Spending Account Claim Form

Employee Name	
SSN	
Telephone	
Mailing Address	

☐ **MEDICAL CLAIM Attach medical bill(s) that include patient's name, date(s) of service, description of service(s) rendered, amount(s) billed, amount(s) paid**
(For Health Care Claims, please complete Medical Expense Claims section and sign & date bottom line only)

☐ **DEPENDENT CARE To be completed by Day Care Provider**

Medical Expense Claims

Name of Person Receiving Medical Service	Provider Name	Service (s) Provided	Date Expense Incurred	Amount Requested
Total Health Care Expense (Use additional sheet if necessary to list all Health Care Expenses)				

Dependent Daycare Claims (A copy of the paid invoice MUST be attached to this form)

Dependent Name	Dependent DOB	Date of Service From	To	Amount Requested
Total Dependent Care Expense (Use additional sheet if necessary to list all Dependents)				

Dependent Care Provider's Name and SSN or Tax ID# (please print) _____

_____

Dependent Care Provider's Relationship to Employee_____

If provider is a dependent, please supply the dependent's date of birth _____

Provider's Address _____

Provider's Signature _____

To the best of my knowledge and belief, my statements on this request for reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year for myself and/or my legal dependent(s). I certify that these expenses have not previously been reimbursed, nor will they be reimbursed under any other benefit plan and will not be claimed as an income tax deduction.

Employee's Signature _____ Date _____

Mail All Claims To: Pequot Plus Health Benefit Services
PO Box 3620
Mashantucket, CT 06338

Or Fax to: 860-396-6403