Medical Flexible Spending Cafeteria Plan

Claim Form

EMPLOYER INFORMATION

Company Name

EMPLOYEE INFORMATION

Employee Last Name	First Name	Social Security Number	
Street Address	**City**	**State**	**Zip**
Daytime Phone Number	**Email**		

MEDICAL EXPENSES

Date of Service	Expense Description	Name of Service Provider	Person Receiving Service & Relationship	Amount of Expense
			Total:	

ELIGIBLE EXPENSES (partial list)**:**

- Insurance co-payments, insurance deductibles, insurance out-of-pocket minimums, well-care checkups, prescription and over-the counter drugs, psychiatric care, therapy;
- Transportation primarily for medical care;
- Dental work (including preventative care), corrective eye surgery (PRK and LASIK), eye glasses, contact lenses and solutions;, hearing expenses (aids, exam, batteries) ;
- Lodging and meals incidental to institutionalization for medical care;
- Rental of medical equipment, disabled dependent care expenses, stop-smoking

INELIGIBLE EXPENSES (partial list)**:**

- Cosmetic procedures;
- Insurance premiums;
- Finance charges;
- Taxes

For more information, review IRS publication 502.
http://www.irs.gov/pub/irs-pdf/p502.pdf

TERMS AND CONDITIONS

1. I request payment from my reimbursement account for the expenses itemized above.
2. I certify that I (and/or my spouse and/or eligible dependents) have not requested reimbursement under this plan or from any other source for these expenses.
3. I further certify that I am fully responsible for the integrity and accuracy of all the information relating to this claim.
4. I understand that reimbursement expenses cannot be claimed on my personal income tax return.

I have read and agree to the terms and conditions set forth on this Agreement.

Employee Signature	Date

Send completed form and documentation to TotalBen. **FAX:** (718) 535-7071 or **Mail:** TotalBen LLC
P.O. Box 100496
Brooklyn, NY 11210

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