125-FSA

Section 125 Flexible Spending Account (FSA) Claim Form

Mail or fax this form with documentation to:
Diversified Benefit Services, Inc.
P.O. Box 260
Hartland, WI 53029
Fax: (262) 367-5938
For additional claim forms log on at www.dbsbenefits.com

Employee Name (please print): _____

Email Address: _____ **Participant ID Number or Social Security Number:** _____

Name of Your Employer (please print): _____

Employee Signature: _____ **Date:** _____ / _____ / _____

Indicate here if your address/information has changed:

_____

_____

_____

SECTION 125 FLEXIBLE SPENDING ACCOUNT (FSA)
SEE INSTRUCTION GUIDE IN REIMBURSEMENT KIT

Complete this section if you want reimbursement for care of a dependent that was provided by a childcare facility, adult dependent care center or individual.

CLAIM TYPE I: DEPENDENT CARE REIMBURSEMENT ACCOUNT

Amount of expense incurred: $_____

Name of dependent care provider: _____

Social Security Number: _____

OR Federal Tax ID number of dependent care provider: _____

Dates of Service **(within plan year)**: From: _____ To: _____

Signature of **(or attach receipt from)** dependent care provider: _____

OFFICE USE ONLY A: _____ D: _____

Complete this section if you want reimbursement for medical, dental, vision, etc. type expenses.

CLAIM TYPE II: MEDICAL REIMBURSEMENT ACCOUNT

Amount of expense incurred: $_____

Dates of Service: From: _____ To: _____

Check if for orthodontia (braces): ❒

You must attach proper documentation with dates of service, description and nature of expense and amount of out-of-pocket expense.

OFFICE USE ONLY A: _____ D: _____

Complete this section for independent insurance premiums (such as private medical and/or dental insurance, Medicare Part B).

CLAIM TYPE III: INDEPENDENT PREMIUM FEATURE

Amount of expense incurred: $_____

Premium billing period (within the plan year): From: _____ To: _____

You must attach a copy of the independent insurance premium billing. This is not for reimbursement of group insurance premiums paid through your employer.

OFFICE USE ONLY A: _____ D: _____

By signing this form, I certify that the amounts listed are correct and are expenses that represent qualified reimbursable expenses. I will not claim these items on my personal income tax return for medical itemization nor claim any dependent care reimbursement expenses as a tax credit. I certify that I will not be reimbursed for the expenses listed below from any insurance company or insurance plan or the following: any other Flexible Benefit Plan, Medical Savings Account (MSA), Health Reimbursement Arrangement (HRA), Deductible Reimbursement Plan (DRP), another reimbursement plan or any other source. I also certify that the expenses have been incurred and dates of service are during the timeframe required by the benefit plan. I will also provide documentation necessary to support the amounts being requested for reimbursement.