Flexible Benefit Plan

DEPENDENT CARE CLAIM FORM

Soc Sec or
Employee No: _____Printed Name:_____

The undersigned participant in the plan requests reimbursement in the amounts shown below. Attach itemized bills, receipts, and invoices for all expenses claimed. (If additional space is needed please use back of form.)

Mail, Fax or Email to: HealthCare Solutions Group, Inc.
P.O. Box 1309
Muskogee, OK 74402
Fax: (918) 781-4979
Email: ctremblay@hsg.com

DEPENDENT CARE EXPENSE

Date Incurred From: _____ To: _____

Dependent(s) Name: _____

Name, Address & Taxpayer I.D. Number of person providing service:
_____
_____
_____

Amount $ _____

READ CAREFULLY
The undersigned participant in the plan certifies that all expenses for which reimbursement or payment claimed by submission of this form were incurred during a period while the undersigned was covered under the (Insert Employer's name) _____Benefit Plan with respect to such expenses. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

Date: _____ Employee Signature: _____

HSG use only:

Payment Authorized _____ *Amount* _____