



**Reimbursement Claim Form**

Complete form to request reimbursement of expenses incurred by you and your dependents. An itemized receipt of services received must be attached to this form

Employee Name

Employer Name

Benefit Codes: **F** - FSA    **D** - Dependent Daycare    **H** - Health Reimbursement Arrangement

Description of Service _____	
Person Receiving Service - Relationship _____	Age _____
Benefit Code <input type="text"/>	Starting Date of Service <input type="text"/> / <input type="text"/> / <input type="text"/> Month                  Day                  Year
Amount \$ <input type="text"/> . <input type="text"/>	Ending Date of Service <input type="text"/> / <input type="text"/> / <input type="text"/> Month                  Day                  Year

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Person Receiving Service - Relationship _____	Age _____
Benefit Code <input type="text"/>	Starting Date of Service <input type="text"/> / <input type="text"/> / <input type="text"/> Month                  Day                  Year
Amount \$ <input type="text"/> . <input type="text"/>	Ending Date of Service <input type="text"/> / <input type="text"/> / <input type="text"/> Month                  Day                  Year

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Amount \$ <input type="text"/> . <input type="text"/>	Ending Date of Service <input type="text"/> / <input type="text"/> / <input type="text"/> Month                  Day                  Year

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and to the best of my knowledge and belief, are eligible for reimbursement under my reimbursement plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return. Any person who knowingly and with intent to injure, defrauds or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law. Where indicated, parking amounts claimed are without an available receipt and this certification includes such expenses.

Please fax or mail completed form to: (425) 771-1226 or mail to PO Box 6 Mukilteo, WA 98275

Signed By \_\_\_\_\_ Date \_\_\_\_\_