



FLEX SPENDING ACCOUNT REIMBURSEMENT FORM

Please FAX this signed and completed form to 480.753.0290
For Customer Service, call 888.810.0165

1. Participant Information and Signature

By submitting this claim form, I (participate named below) request reimbursement from my Flexible Spending Account(s) as listed below. I agree to the Terms and conditions stated below. I certify and warrant to AmCheck that these are eligible. Unreimbursed Medical and/or Dependent Care expenses (See back) that my dependents and I have incurred.

Participant's Name (print name) _____ Social Security Number _____

Participant's Address (complete only if address has changed): _____
Street City State zip

Employer's Name: _____

How may we contact you during the day? E-mail: _____ Phone: _____

Participant's Signature: _____ Date: _____

2. Dependent Care

List each receipt separately. Use additional forms if necessary. Use the provider's certification space below only if no receipt is attached.

Table with 5 columns: Dependent's Name, Age, Provider's Name, Date Service Provided, Requested Amount. Includes three blank rows for data entry.

3. Unreimbursed Medical

List each receipt separately. Use additional forms if necessary. Use the provider's certification space below only if no receipt is attached.

Table with 5 columns: Patient's Name, Provider's Name, Description of Service, Date Service Provided, Requested Amount. Includes three blank rows for data entry.

Provider's Certification/Verification: I certify that the Unreimbursed Medical expenses listed above by the participant named above.

Provider's Address: Street _____ City: _____ Zip: _____
Provider's Signature: _____ Date: _____

4. Terms and Conditions

I (participant named above) understand and agree that:
These expenses are not reimbursed from any other health plan, insurance, or other source, and will not be used to claim any federal income tax deduction or credit.
The unreimbursed Medical expenses listed above would deductible medical expenses under Revenue Code Section 213(d) and are allowed under Prop. Treas.Reg. 1.125-2
The Department Care expenses listed above qualify for the federal childcare credit, and I will not be eligible to claim the tax credit for any Department Care expenses submitted.
I will include the Taxpayer Identification/social Security number(s) of any Department Care service provider(s) listed above on my annual tax return(s) using Form 2441
I am responsible for any inappropriate use or disclosure of my information that occurs due to my selected method of transmitting this information (e.g. fax,e-mail, or any other media)
I authorized the plan its service provider(AmCheck and AmCheck Benefit Service), their respective agents, employees, subcontractors, and assigns to use and/ or disclose the information provided above as they reasonable deem necessary to manage the plan (including but not limited to disclosure to my employer for plan administrative purposes, such as the evaluation of eligibility for reimbursement under the plan) and to detect or prevent fraud or misrepresentation.
I give up any claims related to the use, disclosure, or release of this information so long as the information is used for the purpose defined above.
This authorization does not in any way limit any right that AmCheck and AmCheck Benefit Services, their respective agents, employees, subcontractors, and or any assigns may have under applicable state or federal law o9r regulation regarding the use of such information.