



**FLEXIBLE COMPENSATION PLAN HEALTH CARE SPENDING ACCOUNT  
CLAIM FORM**

Employee Name \_\_\_\_\_

Date of Service	Patient	Service Provider	Amount
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I certify that the statements and information on this claim form are true and accurate to the best of my knowledge. I also certify that I am claiming reimbursement only for eligible expenses incurred during the Plan Year and only for eligible plan participants. I also certify that these expenses have not previously been or will be reimbursed under this or any other benefit plan. I further certify that I will not claim these or any other expenses reimbursed through this plan as an income tax deduction.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

**Attach invoices, receipts, or explanation of benefits statements from your health insurance provider as documentary for claims.**