Request for Reimbursement – Claim form

Employers Name: _____

NAME:	Last name	First	MI		**SS#**	- -	
ADDRESS:	Street	City	State	ZIP	**WORK #**	( )	

Please check if this is a new address ____
E-Mail Address_____

Information below must be completed

(FSA) MEDICAL EXPENSE(s) to be reimbursed						
Date of Service MM/DD/YY	**Patient Name**		**Relationship**	**Name of Provider**	**Description of Service**	**Claim Amount**
						$
						$
						$
						$
						$
						$
						$
						$
					Total:	**$**

DEPENDENT *DAY CARE* CLAIMS (Only)							
Date of Service From	**To**	**Dependent Name**	**Age**	**Dependent Care Provider Name**	**Dependent Care Provider Address**	**Provider Tax Id#/or SS#**	**Claim Amount**
							$
							$
							$
							$
						Total:	**$**

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

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, defraud, 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.

Employee Signature: _____ **Date:** ____ /_/___

FAX TO: (661) 280-2016

WEBSITE: WWW.SHAFFERINS.COM PHONE NUMBER (661) 575-9331/ TOLL FREE (866) 412-5872

OR MAIL TO: SHAFFER INS. SERVICES BENEFITS DIVISION
902 EAST AVENUE Q-9 , PALMDALE, CA 93550-4735