

COUNTY OF SACRAMENTO
FLEXIBLE SPENDING ACCOUNT CLAIM FORM
PLAN YEAR JANUARY 1, 2010 through DECEMBER 31, 2010

Section I – Employee Information

Last Name	First Name	MI	Day Phone	PIN (Personnel Number)
Address		City	St	Zip
				Email

Instructions

1. Complete Section I – Employee Information. This form can only be used for services incurred during the plan year shown above
2. **Do not staple any documentation to claim form, please tape to separate sheet or include loosely in envelope. Do not send originals (all claims are stored electronically and paper copies will be shredded).**
3. Complete Section II – Dependent Care Reimbursement Account Claims. Attach proper documentation showing the date(s) of service, cost of service, name of child and provider's information.
4. Complete Section III – Medical Reimbursement Account Claims. Attach proper documentation showing the date(s) of service, type(s) of service and cost (No cancelled checks, balance forwards or bank card receipts). Itemize all expenses to prevent delays in reimbursement.
5. Complete Section IV - Signing the claim form. Fax or mail a signed claim form, but do not do both. Online claims status is available at www.flex-plan.com. Claims must be submitted at least two (2) full business days prior to the scheduled reimbursement date

Section II – Dependent Care Reimbursement Account

Start Date	End Date	Provider's Name, Tax ID/or SSN	Name of Dependant	Age	Cost
See IRC Section 129 for qualifying Dependent Care expenses or consult your tax advisor for more information.				Total DCRA Request	
				\$	

Section III – Medical Reimbursement Account

Service Dates	Type of Service	Name of Provider	For Whom	Net Cost
See IRC Section 213 for qualifying Health Care expenses or consult a tax advisor for more information.			Total MRA Request	
			\$	

Section IV – Signature

To the best of my knowledge my statements on this claim form are complete and true. I understand that I am solely responsible for the sufficiency, accuracy, and veracity of claims and all information related to these claims submitted to my Health Care ("HCFSA") or Day Care Flexible Spending Account ("DCFSA"), and that unless an expense for which payment or reimbursement is claimed is a proper expense under the HCFSA or DCFSA, I may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid from the HCFSA or DCFSA which relate to such expense. I further understand that no dependent care tax credit is permitted for amounts for which reimbursement is made. I am claiming health care reimbursement for eligible medical care expenses incurred by myself, spouse, and/or dependents during the plan year shown above and certify that these expenses have not been reimbursed under this plan or by any other source and that they will not be reimbursed by any other source or insurance. By providing my email address, I am requesting that all possible communications regarding this claim may be sent via email. I hereby authorize my HCFSA and/or DCFSA to be reduced by the amount(s) shown above.

Participant's Signature X	Date
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Fax completed form and documentation to:
FAX: toll-free (866) 535-9227

OR

Mail forms and documentation to: Flex-Plan Services, Inc.
PO Box 70366 Bellevue, WA 98007

Customer Service Line: (800) 669-FLEX Visit our Web site at www.flex-plan.com