FLEXIBLE SPENDING ACCOUNT CLAIM FORM

Send completed form:
Mail: P.O. Box 1688, Pascagoula, MS 39568
Email: flex.t2@90degreebenefits.com
Fax: 228-769-0401
Questions: Call 228-762-2500

Employer Name Bay County Board of County Commissioners **Group #** _____

DEMOGRAPHIC INFORMATION

Employee Name _____
Last First Middle Initial

ID # _____ **Date of Birth** _____

Address _____
☐ Check for New Address
Street City State Zip Code

Email Address _____ **Phone Number** ( ) _____

HEALTHCARE EXPENSE CLAIM

Date of Service MM/DD/YY	Patient Name	Relationship	Provider Name	Description of Service	Amount Requested*
				TOTAL AMOUNT REQUESTED $	

*Acceptable forms of documentation: **Explanation of Benefits (EOB's)** for your insurance carrier showing your obligation. **Reciepts** that include patient name; date of service; type of service; provider name; and amount of expense. (IRS does not allow credit card receipts).

DEPENDENT CARE EXPENSE CLAIM

Date of Service From / To		Dependent Name	Age	Provider Name	Provider Address	Provider Tax ID# / SS#	Amount Requested
						TOTAL AMOUNT REQUESTED $	

- Proof of expenses must be attached and must include: dates of service; the provider name; provider address; identification number or social security number. If proof of expense is not available, proper completion of the Expense Claim form will be considered proof of expense.
- By signing below I acknowledge the dependent care information is correct to the best of my knowledge. I understand I may incur penalties of perjury if the information is knowingly misstated.
- Checks cannot be issued for amounts greater than the current account balance or services not yet provided.

EMPLOYEE CERTIFICATION FOR REIMBURSEMENT

I authorize my account(s) to be reduced by the amount requested. To the best of my knowledge and belief, the statements on this form are complete and true. I am claiming reimbursement only for eligible expenses incurred by eligible plan participants during the applicable plan year. I certify that these expenses have not previously been reimbursed by this or any other benefit plan, will not be reimbursed from any other source and will not be claimed as an income tax deduction. I also understand that I may be asked to provide further details.

Employee Signature: _____ **Date:** _____