

**Messiah College**  
**FLEXIBLE SPENDING ACCOUNT CLAIM FORM**  
**FOR PLAN YEAR JULY 1, 2008 through JUNE 30, 2009**

**Section I – Employee Information**

|   |  |
|---|--|
| Last Name, First Name _____ MI _____ Day Phone _____<br><br>Address _____ City _____ St _____ Zip _____<br><input type="checkbox"/> <b>Address Change</b> | Employee SSN<br>□ □ □ - □ □ - □ □ □ □<br><br>Email _____ |
|---|--|

**Instructions**

1. Complete Section I – Employee Information. This form can only be used for services incurred during the plan year shown above. Do not use this form for Benny™ Card transactions.
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 – Day Care Claims. Attach proper documentation showing the date(s) of service, cost of service, dependent’s name, and provider’s name and tax ID or social security number (**No cancelled checks, balance forwards, or bank card receipts**).
4. Complete Section III – Health Care 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](http://www.flex-plan.com). Claims must be submitted at least two (2) full business days prior to the scheduled reimbursement date

**Section II – Day Care FSA**

| Start Date   | End Date | Provider’s Name, Tax ID/or SSN | Name of Dependent | Age                               | Cost |
|--|----------|--------------------------------|-------------------|-----------------------------------|------|
|  |          |                                |                   |                                   |      |
|  |          |                                |                   |                                   |      |
| See IRC Section 129 for qualifying Dependent Care expenses or consult your tax advisor for more information. |          |                                |                   | <b>Total Day Care FSA Request</b> |      |
|  |          |                                |                   | \$                                |      |

**Section III – Health Care FSA**

| 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. |                 |                  | <b>Total Health Care FSA Request</b> |          |
|  |                 |                  | \$                                   |          |

**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 (“HCFS”) or Day Care Flexible Spending Account (“DCFS”), and that unless an expense for which payment or reimbursement is claimed is a proper expense under the HCFS or DCFS, I may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid from the HCFS or DCFS 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 HCFS and/or DCFS to be reduced by the amount(s) shown above.

|  |            |
|--|------------|
| Participant’s Signature <b>X</b> _____ | Date _____ |
|--|------------|

**Fax completed form and documentation to:**  
**FAX: (425) 451-7002 or toll-free (866) 535-9227**

**Email:**  
**[claims@flex-plan.com](mailto:claims@flex-plan.com)**

**Mail forms and documentation to: Flex-Plan Services, Inc.**  
**PO Box 53250 Bellevue, WA 98015-3250**

Customer Service Line: (425) 452-3500 or (800) 669-FLEX Visit our Web site at [www.flex-plan.com](http://www.flex-plan.com)