



www.ezflexplan.com/bcbsla

Employer _____
Your Name _____ Social Security Number _____

Mailing Address: _____
(Please print clearly) Street or P.O. Box _____ City/State/Zip _____

Check if new address

Dependent Day Care Expense Claims

Name of Dependent(s)	Period Covered		Name, Address and Taxpayer Identification Number of Provider of Service	Amount Incurred
	From	To		
*TOTAL DEPENDENT CARE EXPENSE CLAIM				

***NOTE:** The total amount claimed under the Plan for any coverage period must not exceed the lesser of your earned income for the plan year or the earned income of your spouse. (If your spouse is either a full-time student or is incapable of taking care of himself or herself, then he or she is deemed to have monthly earnings of \$200 if there is one (1) child or dependent, and \$400 if there are two (2) or more.) No payment may be made under the Plan if the service provider is your dependent for federal income tax purposes, or is your child or stepchild and is under age 19.

Unreimbursed Medical Expense Claims

Date Expense Incurred	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount
TOTAL MEDICAL CARE EXPENSE CLAIM				

READ CAREFULLY

****See Reverse Side For Guidelines****

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the Employer's Flexible Spending Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage and have not been previously submitted. The undersigned fully understands that **he or she alone is fully responsible** for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, **the undersigned may be liable for payment of all related taxes** including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

Employee's Signature Date

Guidelines for Submitting Cafeteria Plan Claims

CLAIM FORM VOUCHERS MUST BE COMPLETED WITH THE FOLLOWING:

- Signature of the employee
- Explanation of Benefits indicating payment/denial of corresponding charges
- Pharmacy receipts/statements

NOTE: Balance forward statements, charge receipts, payment on account, or canceled checks ARE NOT ACCEPTABLE.

DEPENDENT DAY CARE CLAIMS

Employees may submit a Constant Voucher form available from Blue Cross and Blue Shield of Louisiana Flex Plan which is completed by the day care provider. The form is to include the yearly total to be filed, therefore, no monthly receipts are required and day care reimbursement checks will automatically be issued to the employee each month.

If no constant form is submitted, the employee must provide a day care receipt to include the name and Tax ID number of the day care provider in order for reimbursement to be made. Copies of cancelled checks are not

acceptable.

NOTE:

Please be advised as indicated on the Claim for Reimbursement form it states it is the responsibility of the employee that expenses filed have not been filed or reimbursed by any health plan coverage or previously submitted to BCBSLA for reimbursement as we DO NOT check for duplicates. The employee is fully responsible for the sufficiency, accuracy, and veracity of all information provided.