

**Submit Claims To:**

Pam Singer  
 Section 125 Administrator  
 ResourceOne Administrators  
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 877-233-0970 phone  
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**Claim For Reimbursement**

Employer \_\_\_\_\_

Name \_\_\_\_\_ Last 4 digits of SSN \_\_\_\_\_ Employee # \_\_\_\_\_

**Dependent Care Expense Claims**

| Name of Dependents                        | Period Covered |    | Name, Address and Taxpayer Identification Number of Provider of Service | Amount Incurred |
|---|----------------|----|---|-----------------|
|   | From           | To |   |                 |
|   |                |    |   |                 |
|   |                |    |   |                 |
|   |                |    |   |                 |
|   |                |    |   |                 |
|   |                |    |   |                 |
|   |                |    |   |                 |
| <b>TOTAL DEPENDENT CARE EXPENSE CLAIM</b> |                |    |   |                 |

\*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 |
|---|--------------------------|---------------------|----------------------------------|------------|
|   |                          |                     |                                  |            |
|   |                          |                     |                                  |            |
|   |                          |                     |                                  |            |
|   |                          |                     |                                  |            |
|   |                          |                     |                                  |            |
| <b>TOTAL MEDICAL CARE EXPENSE CLAIM</b> |                          |                     |                                  |            |

**READ CAREFULLY**

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 Company'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. 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