



Flexible Benefit Plan Reimbursement Claim Form

Employer: _____

Name: _____ **Employee ID:** _____
(last 4-digits of SSN)

Email Address: _____

Dependent Daycare Expense Claims

Name of Dependents	Dates of Service From To	Provider Name, Address and Taxpayer Identification Number	Amount Incurred
Attach a receipt from your daycare provider or include provider's signature			Total Dependent Care Expenses <small>Provider Signature:</small>

*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 him 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.

Medical Reimbursement Expense Claims

↓Select One↓

Date Expense Incurred	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Request For Reimb	Used MBI Card	Net Amount
Attach valid receipt(s) - Credit card receipts are NOT acceptable			Total Medical Care Expenses			

READ CAREFULLY

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form have been incurred during the period while the undersigned was covered under the Company's Flexible Benefit Plan with respect to such expenses and that the medical expenses have not been reimbursed nor will the participant seek reimbursement for the expenses under any other plan covering health benefits. **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

Daytime Telephone Number

Leggette Actuaries, Inc.
4131 North Central Expressway, Ste 1100, Dallas, TX 75204
800-388-4015 Tel 214-443-0606 Fax Flex@Leggette.com