Flexible Spending Account Claim Form

Division:

Print Your Name

Social Security #

Street

City, State, Zip

Phone Number

I request reimbursement (copies of itemized bills, receipts, and/or invoices are attached detailing all expenses) in the amount shown below: (use back of form if additional space is needed)

HEALTH CARE REIMBURSEMENT

Date Incurred	Name of Service Provider	Describe Expense	Person/Relationship For Whom Expense Incurred	Amount of Expense
			Total Amt:	
			Total Amt of Health Care Reimbursement:	

DEPENDENT DAY CARE REIMBURSEMENT:

Date Services Provided From To	Service Provider Name, Address and TAX ID Number		Person/Relationship For Whom Expense Incurred	Amount of Expense
			Total Amount of Dependent Care Reimbursement:	

READ CAREFULLY:

I certify that all expenses for which reimbursement or payment is requested by submission of this form were incurred during a period while I was covered under the Nexcaliber Health Care Reimbursement Plan, and/or Dependent Care Reimbursement Plan with respect to such expenses. I fully understand that I alone am fully responsible for the sufficiency, accuracy and authenticity of all information relating to this reimbursement request, and that unless an expense for which payment or reimbursement is requested is a proper expense under the plan, I 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

Complete and mail this form with attached documentation to:

Nexcaliber
PO Box 802422
Dallas, TX 75380
Fax: (972) 248-1405

ADDITIONAL HEALTH CARE EXPENSES

Date Incurred	Name of Service Provider	Describe Expense	Person/Relationship For Whom Expense Incurred	Amount of Expense
	Total Amount of Health Care Expenses to front of form:			

DEPENDENT DAY CARE EXPENSE

Effective January 1, 1989, the Internal Revenue Service (IRS) requires the name, address, and Tax I.D. number for all Day Care providers. If your Day Care provider is:

1 A self-employed individual, IRS requires their Social Security Number.
2 A facility, IRS requires their Federal Tax I.D. Exempt Number.
3 Affiliated with a church, IRS requires their Tax Exempt Number.

1 Name of Provider _____ Tax I.D. # _____
Street _____
City, State Zip _____

2 Name of Provider _____ Tax I.D. # _____
Street _____
City, State Zip _____