Section 125 *Dependent Care* Reimbursement Request Form
Section 125 *Insurance Premium* Reimbursement Request Form

Section 1 This section must be completed fully for all claims. **(PLEASE PRINT)**

EMPLOYER NAME: _____

EMPLOYEE NAME: _____

ADDRESS: _____

☐ **Check if this is a NEW address** EMPLOYEE DAY TIME PHONE NUMBER: _____

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____

Section 2 This section is for **DEPENDENT CARE** claims only. This section must be completed for all claims incurred by you, your spouse, or other eligible dependents. Supporting documentation **MUST** be attached. We want to promptly process your claims. Please complete all appropriate sections as the claim form will be returned to you if incomplete. Use an additional form if you need more space. Please keep a copy of this form for your records.

DAY CARE/DEPENDENT CARE INFORMATION:

Period Covered	Provider's Full Name	Provider's Tax ID	Amount Requested
			$
			$
			$
			$
			$
			$
			$
		TOTAL AMOUNT REQUESTED	$

Section 3 This section is for **INSURANCE PREMIUM** claims only. This section must be completed for all claims incurred by you, your spouse, or other eligible dependents. Supporting documentation **MUST** be attached. We want to promptly process your claims. Please complete all appropriate sections as the claim form will be returned to you if incomplete. Use an additional form if you need more space. Please keep a copy of this form for your records.

INSURANCE INFORMATION:

Date Paid	Period Covered	Insurance Carrier's Full Name	Amount Requested
			$
			$
			$
		TOTAL AMOUNT REQUESTED	$

Section 4 Employee's Signature is required to process this claim.

To the best of my knowledge, my statements in the request for reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the application plan year and for eligible plan participants. I certify that these expenses have not been previously reimbursed under this or any other benefit plans and will not be claimed as an income tax deduction. I authorize my FlexPay medical accounts to be reduced by the amount requested.

SIGNATURE: _____ **DATE**: _____

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