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CLAIM FOR REIMBURSEMENT

Please make copies and save for future claims filing

Name: _____ Last Four Digits of SSN: _____

Employer: _____ Email: _____

Dependent Care/Day Care Expense Claims

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

Medical Expense Claims *(for you and/or your eligible dependents)*

Date Incurred	Name of Service Provider	Expense Description	Person for Whom Expense was Incurred	FSA	HRA	Amount Incurred
			TOTAL MEDICAL CARE EXPENSE CLAIM			$

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 Cafeteria Plan with respect to such expenses and that the medical expenses have not been reimbursed and will not be reimbursed 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 relates to such expense.

Employee's Signature: _____ Date: _____

Please submit this claim form along with substantiating receipts or for HRAs Explanation of Benefits (EOB). *Receipts must indicate the dates of service, the name of the provider, the nature of the service rendered or product purchased,the person for whom the service was provided and the cost of the service)*

Fax Toll Free: 877-723-0147 or email to claims@amben.com

No Fax Machine?

Mail to: American Benefits Group, P.O. Box 1209, Northampton, MA 01061-1209

800-499-3539