



INTEGRATION. ADMINISTRATION. COMPLIANCE.

Medical and Dependent Care Claim Form

Company Name _____

Participant's Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Social Security #(last 4 digits) _____ Check box if name/address change

Expenses

Table with 4 columns: Date(s) of Service, Name of provider ex. CVS Pharmacy, General description of expense ex. prescription, Amount requested for reimbursement. Includes a total row at the bottom.

Receipts must be submitted with this claim form

Mail Form and Receipts to: Payroll Systems, Flex Claims, 1990 N. California Blvd, Ste 18, Walnut Creek, CA 94596

Fax Form and Receipts to: Payroll Systems, Flex Claims, 925-939-5927

Email Form and Receipts: customersupport@payroll-us.com

Questions: Claims Department 800-696-8004 or email customersupport@payroll-us.com

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 employer's Flex Plan with respect to such expenses and that the expenses have not been reimbursed and are not reimbursable from any other source. 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. All payment of claims is from the employer's general assets.

Participant's Signature _____ Date _____