DIVERSIFIED BENEFIT SERVICES, INC.
Dedicated to Excellence in Benefit Management Solutions

125-FSA

Section 125 Flexible Spending Account (FSA) Claim Form

Mail or fax this form with documentation to:
Diversified Benefit Services, Inc.
P.O. Box 260
Hartland, WI 53029
Fax: (262) 367-5938
For additional claim forms log on at www.dbsbenefits.com

Participant Name (please print): _____

Email Address: _____ **Last four digits of SS#** ___ ___ ___ ___

Name of Your Employer (please print): _____

Employee Signature: _____ **Date:** _____ / _____ / _____

Indicate here if your address/information has changed:

_____

_____

_____

Complete this section if you want reimbursement for care of a dependent that was provided by a childcare facility, adult dependent care center or individual.

Complete this section if you want reimbursement for medical, dental, vision, etc. type expenses.

Complete this section for independent insurance premiums (such as private dental and/or vision insurance, Medicare Part B & D).

SECTION 125 FLEXIBLE SPENDING ACCOUNT (FSA)
SEE INSTRUCTION GUIDE IN REIMBURSEMENT KIT

CLAIM TYPE I: DEPENDENT CARE REIMBURSEMENT ACCOUNT

Amount of expense incurred: $_____

Name of dependent care provider: _____

Social Security Number: _____

OR Federal Tax ID number of dependent care provider: _____

Dates of Service **(within plan year)**: From: _____ To: _____

Signature of **(or attach receipt from)** dependent care provider: _____

OFFICE USE ONLY A: _____ D: _____

CLAIM TYPE II: MEDICAL REIMBURSEMENT ACCOUNT

Amount of expense incurred: $_____

Dates of Service: From: _____ To: _____

Check if for orthodontia (braces): ❒

You must attach proper documentation with dates of service, description and nature of expense and amount of out-of-pocket expense.

OFFICE USE ONLY A: _____ D: _____

CLAIM TYPE III: INDEPENDENT PREMIUM FEATURE

Amount of expense incurred: $_____

Premium billing period (within the plan year): From: _____ To: _____

You must attach a copy of the independent insurance premium billing. This not for reimbursement of group insurance premiums paid through your employer or any type of individual health premium.

OFFICE USE ONLY A: _____ D: _____

By signing this form, I certify that the amounts listed are correct and are expenses that represent qualified reimbursable expenses. I will not claim these items on my personal income tax return for medical itemization nor claim any dependent care reimbursement expenses as tax credit. I certify that I will not be reimbursed for the expenses listed below from any insurance company or insurance plan or the following: any other Flexible Benefit Plan, Medical Savings Account (MSA), Health Reimbursement Arrangement (HRA), Health Savings Account (HSA), another reimbursement plan or any other source. I also certify that the expenses have been incurred and dates of service are during the timeframe required by the benefit plan. I will also provide documentation necessary to support the amounts being requested for reimbursement. In addition, by signing this document, I acknowledge and agree that DBS may, in the case of an overpayment (fraudulent, inadvertent or otherwise), offset future expense reimbursements to me to account for such an overpayment. I also agree to immediately inform DBS if I become aware of an overpayment and agree to reimburse the Plan Sponsor to the extent that an offset of future reimbursements is either impossible or inconvenient. Finally, I certify that I am aware that I may be reimbursed from the Plan only for my own expenses, expenses of my spouse, and expenses of my "dependent" children as defined by my employer's Plan.