Employers Direct Health

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Flexible Spending Account

Reimbursement Claim Form

Employer YOUTH FOCUS (FX173)

Employee Name _____ Social Security # _____

Phone # _____ E-mail _____

Day Care Reimbursement Expenses

Name of Dependent(s)	Period Covered From	Period Covered To	Name, Address, and Taxpayer Identification Number of Provider of Service	Amount Incurred

Provider's Signature:	
Total Child Care Expense Claim*	

➔ Attach a receipt from daycare provider, or include the daycare provider's signature.

* **Note:** The total amount claimed under the Plan for any coverage period must not exceed the lesser of your earned income for the Plan Year or the earned income of your spouse. (If your spouse is either a full-time student or is incapable of taking care of himself or herself, then he or she is deemed to have monthly earnings of $250 if there is one (1) child or dependent, or $500 if there are two (2) or more.) No payments may be made under the Plan; if the service provider is your dependent for federal income tax purposes; or is your child or stepchild and is under age 19. Maximum amount that can be claims is $5000, if filing status is married filing joint. If filing status of income tax is married filing separately then the maximum that can be claims is $2500.00

Health Care Reimbursement Expenses

Date Expense Incurred	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount
		Total Medical Care Expense Claim		

➔ Attach appropriate receipt(s) and submit with this claims form

Read Carefully: The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided 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 or are not reimbursable 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 relate to such expense.

_____ _____

Employee's Signature Date