Flexible Spending Account Claim Form

Company Name	Page of
Employee Name	Social Security #
Phone	Email

DEPENDENT CARE EXPENSE CLAIMS

Name of Dependent(s)	Period Covered From	Period Covered To	Name, Address and Taxpayer Identification Number of Service Provider	Amount Incurred
Attach a receipt from your daycare provider; or include the daycare provider's signature.			*Provider's signature:*	

*Total $ $0.00

*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 $200 if there is one (1) child or dependent, and $400 if there are two (2) or more). No payment 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.

UNREIMBURSED MEDICAL EXPENSE CLAIMS

Date Expense Incurred	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount
Please attach receipts & submit with claim form			Total $ $0.00	

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 Flexible Spending Account with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan. 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 (required) **Date**

Submit Claims To: PB&H Benefits, LLC
Attn: Flexible Benefits Director
401 W. Highway 6
P.O. Box 20725
Waco, Texas 76702-0725
Fax: (254) 772-0455
Email: dmoon@pbhcpa.com

Questions?
Please call:
(254) 741-6688 Local
(888) 629-2363 Toll Free
Or visit us at:
www.pbhbenefits.com