businessolver™

Flexible Spending Account Claim Form

Do not use this form for swipe card transactions

EMPLOYER NAME:

Employees Name: _____
Mailing Address: _____
_____
Email Address: _____
Telephone #: ___(_____)_____

Total Healthcare Reimbursement Requested: $_____

Total Dependent Care Reimbursement Requested: $_____

Date of Service	Provider Name	Description	Amount
			$
			$
			$
			$
			$

The undersigned Employee certifies that all expenses hereby submitted are for services incurred during the current Plan Year. Furthermore, by signing, the Participant also certifies that these expenses are not reimbursable, in whole or in part, under any other plan of insurance or other benefit. The Employee understands that he/she is responsible for the accuracy and veracity of expenses submitted and that he/she may be responsible for any tax consequences and/or penalties arising from improper submission and reimbursement of the above expenses under the Participant's Section 125 Cafeteria Plan.

Signature/Date: _____/_____

Please attach all receipts and proof of expenses to this form.

Mail completed form and receipts to: Section 125 Claims Department
Businessolver, Inc.
PO Box 65948
West Des Moines, IA 50265

OR Fax to: 855-883-8542
For Claims inquiries, please call: 855-883-8541
OR
Email to: Flexadministration@businessolver.com