TAXSAVER PLAN

Flexible Spending Account Claim Form

Submit Claim To:
Taxsaver Plan
P.O. Box 609002
Dallas, Texas 75360
800-328-4337 TOLLFREE
214-559-0472 DFW AREA
214-528-8122 FAX
www.taxsaverplan.com

Name of Employer

Employee Last Name First Name (please print) Employee ID Number

Dependent Day Care Expenses for Reimbursement

Please provide receipt OR complete the following information:

$_____Service Dates of Day Care from __/ ___00__ to __/ __200__

Dependent(s) Name(s) _____, _____, _____, _____
Dependent(s) Age(s) _____(only required for Dependent Day Care Reimbursement)

I certify that I have provided the custodial care for the dependent(s) named above for the service dates mentioned above.

_____ _____

Date Day Care Provider Signature

****Please note the employee must still complete the Participant Certification portion of this form**

Health Care Expenses for Reimbursement

Health Care Expenses (*Request for reimbursement* of non-benefit card expense(s)) $_____

OR CHECK ONE OF THE FOLLOWING:

[ ] This is an MBI Benefit Card Expense (not a *personal bank account debit card* transaction)

[ ] This expense should be used to offset my outstanding MBI Benefit Card transaction(s), in the amount of

$_____as I am unable to produce the receipt(s) or I have used the card for an ineligible item(s).

Participant Certification

(this section must be signed and dated for reimbursement requests)

I testify that I have attached records necessary to substantiate these expenses. I understand that since these expenses are reimbursed through my spending account that they may not be claimed on any federal income tax deduction or credit at year end. I further certify that I will not submit these expenses for payment by a third party, such as my major medical plan, or any other health plan, such as an individual policy or my spouse's or dependents health plan. If this expense was paid for with my Flex Debit Card, I understand that the card is not to be used for personal items, other than eligible expenses under the Plan. Should I use the card for ineligible expenses, I am required to reimburse the Plan for the ineligible expenses paid for by the card. I attest that any over the counter expenses have been incurred for the primary purpose of the alleviation or prevention of a physical or mental defect or illness and is not for cosmetic purposes and will be used by myself, spouse and/or dependents. All expenses submitted for request of reimbursement or claim substantiation are for myself and / or qualified spouse and / or qualified dependent(s) under federal guidelines.

_____ _____

Date Employee Signature

Documentation Required:

Dependent Care Expenses: You must submit itemized receipts that substantiate the date of care, amounts paid for the care and the name of the provider OR have your day care provider sign the Dependent Day Care Reimbursement portion of the claim form certifying that services have been rendered.

Health Care Expenses: You must submit Health Plan receipts (Explanation of Benefits) sent from your health plan provider that substantiate deductibles, co-pays, co-insurance or other expenses not covered by a health plan, Itemized receipts from health care providers that substantiate the date of service, type of service cost of service and the name and phone number of the provider or Itemized receipts for eligible over the counter expenses with the name of the drug or item and the date of the purchase printed on the receipt from an independent third party. *Please note - balance forward statements, canceled checks and credit card receipts are **not** acceptable.*