

Marple Newtown School District

FLEXIBLE SPENDING ACCOUNT CLAIM FORM

Employee's Name		Employee's Social Security Number		School/Location	
Employee's Address				Work Phone:	
				Home Phone:	
For Dependent Care Claims or Medical Claims for a Dependent:					
Dependent's Full Name		Dependent's Social Security Number		Date of Birth	
				Handicapped <input type="checkbox"/>	Full-Time Student <input type="checkbox"/>

Separate forms must be used for Medical or Dependent Care claims.
Please check only one: Medical Claim Dependent/Elder Care Claim

Medical Care Claims and Dependent Care Claims MUST be on separate claim forms.	Dates of Service		Provider's Name. <small>For Dependent Care, Providers Tax ID MUST be included.</small>	Description of Services Received	Expense Amount	Third Party Reimbursement	Requested Amount	
	From	To						
Claim Total:								

MEDICAL CARE REIMBURSEMENT ACCOUNT CERTIFICATION:

My signature below certifies that Medical Care expenses as submitted herewith, have been incurred and paid by me, my spouse, or my dependent (s), and have not or will not be reimbursed from any other source and have not or will not be used by me, my spouse or my dependent (s) as deductions in filing income tax returns.

DEPENDENT/ELDER CARE REIMBURSEMENT ACCOUNT CERTIFICATION: ** Provider's Federal ID Number must be included with claim

My signature below certifies that Dependent/Elder Care Expenses, as submitted herewith, have been incurred for household services or for the care of a "qualifying individual" to enable me to be gainfully employed. I understand that a qualifying individual is (i) a dependent of mine under age 13, (ii) a dependent of mine who is physically or mentally unable to care for himself/herself. I certify that my Spouse, if any, was either employed, a full-time student or incapable of caring for himself/herself during the period the expenses were incurred.

I hereby agree to reimburse my Flexible Spending Account maintained at Brokerage Professionals, Inc. in full should this claim be incorrectly paid.	Signature:	Date
---	------------	------

Marple Newtown School District FLEXIBLE SPENDING ACCOUNTS

Employee instructions and information for completing this form.

1. Complete all employee information questions. Separate Claim forms must be used for Medical Claims and Dependent/Elder Care claims.
2. Complete all dependent information questions, if the claim expenses are for a dependent, (submit one claim form per dependent).
3. Indicate the dates for services rendered, name of provider along with a brief description of the services and amount of reimbursement you are requesting. The TAX ID must be provided for Dependent Care Claims.
4. When requesting reimbursement for medical expenses, a copy of the explanation of benefits provided by any insurer or claims processor must also be attached when coordination of benefits is involved.
5. Be sure to attach itemized receipts for all items claimed. Claims without itemized receipts will be declined.
6. Once the form is completed, attach all receipts and any explanation of benefit statements and return it to the Plan Administrator*.
7. The provisions of this plan reserve to the Administrator and the Claims Processor the right to reject requests for reimbursement which they believe are not supported by proper documentation or do not qualify as reimbursable expenses under this Plan.
8. If you have any further questions regarding the submission of your claims, please contact the Plan Administrator, Susan E. Larkin at (610) 566-4920.
9. If you need additional Claim Forms, contact the Plan Administrator.

*** PLAN ADMINISTRATOR**

BROKERAGE PROFESSIONALS

40 WEST FRONT STREET

MEDIA, PA 19063

Tel: (610) 566 - 4920

Fax: (610) 627 - 0256

e-mail: benefits@brokerprofs.com