P.O. Box 25160
Scottsdale, AZ 85255-0102

PHONE (480)505-0400
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# FLEXIBLE SPENDING ACCOUNT PLAN

Claim form for **Dependent Care or Un-Reimbursed Medical Expenses**

PROCEDURE FOR FILING:

1. COMPLETE THIS CLAIM FORM TO PROVIDE INFORMATION (*Request for reimbursement Should be done monthly)*
2. ATTACH ITEMIZED PAID RECEIPTS.

**EMPLOYER/SPONSOR NAME: Casa Grande Elementary School District #4**

**EMPLOYEE/MEMBER NAME:** ______________________________

**SOCIAL SECURITY #:** ____________________ **PHONE#** ____________________

**STREET ADDRESS:** ______________________________

**CITY/STATE/ZIP CODE:** ______________________________

* * * * * * * * * * * * * * * * * * * * *

I AM FILING THE FOLLOWING EXPENSES FOR REIMBURSEMENT FROM MY DEPENDENT CARE OR UN-REIMBURSED MEDICAL EXPENSE FLEXIBLE SPENDING ACCOUNT:

| PROVIDER NAME: | | |
|---|---|---|
| PROVIDER ADDRESS: | | |
| | | |
| PROVIDER SS NUMBER OR FED TAX ID: | | |
| SERVICES FROM: | TO: | $ |
| SERVICES FROM: | TO: | $ |
| SERVICES FROM | TO: | $ |
| | **TOTAL** | **$** |

I CERTIFY, UNDER PENALTY OF PERJURY, THE ITEM(S) ATTACHED ARE TRUE AND CORRECT, AND THAT THE AMOUNTS REQUESTED ARE FOR CLAIMS INCURRED AND PAID BY ME (AND/OR MY ELIGIBLE DEPENDENTS). I ACCEPT RESPONSIBILITY FOR THE PROPER TREATMENT OF BENEFITS PAID UNDER THE PLAN WITH RESPECT TO ALL INDIVIDUAL INCOME TAX REPORTING AND VERIFY THE CLAIM IS FOR EXPENSES NOT REIMBURSED BY ANY OTHER PLAN.

MEMBER SIGNATURE:____________________ DATE:____________________

MAIL THIS FORM AND ORIGINAL RECEIPTS TO:

/\Summit

**P.O. Box 25160**
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FORM-SUMMIT-FSA-CGESD