

StLL Flex

StLL Flex Claim Form
 Medical & Dental Reimbursement Account
 Dependent Care Reimbursement Account

Claim Form Instructions:

- 1) Dated copies of receipts from baby sitters, bills from day care centers, or canceled checks for day care services need to be included with the Claim Form as proof of eligible expenses.
- 2) All areas of the Claim Form must be completed for any claim to be processed.
- 3) If you have any questions, please call the Claims Administration Office at (315) 287-2028, or write at:
 St. Lawrence-Lewis
 Claims Administration Office
 PO Box 300
 Richville, NY 13681

Fill out the following information:

School District: _____

Employee Name: _____

Employee SS# _____

Employee Phone Number: _____

Employee Address: _____

(Please check here if address has changed)

	Date of Service	Amount	Description of Service	Provider of Service If for Dependent Care Reimbursement fill in provider's SS# (babysitter) or Tax ID # (day care centers) - Must Be Completed	Claimant Name	Relationship to Employee (i.e. Self/Spouse/Child/Other - Must Specify)
<input type="checkbox"/> Med/Dent <input type="checkbox"/> Dep Care						
<input type="checkbox"/> Med/Dent <input type="checkbox"/> Dep Care						
<input type="checkbox"/> Med/Dent <input type="checkbox"/> Dep Care						
<input type="checkbox"/> Med/Dent <input type="checkbox"/> Dep Care						

I certify that the expenses for which reimbursement is being requested have been incurred for myself, my spouse, and/or my dependents. Any medical and/or dental expenses for which I am requesting reimbursement are expenses which have not been reimbursed and are not reimbursable under any other health plan coverage. Any dependent day care expenses for which I am requesting reimbursement are expenses which have not been reimbursed and are not reimbursable under any other program. I understand that I must provide the taxpayer identification number of the dependent day care provider on my federal income tax return if I am requesting reimbursement of dependent day care expenses, and I will comply with this requirement. My spouse is not claiming reimbursement for the dependent care expenses under any coverage provider by his/her employer.

Signature

Date