StLL Flex Claim Form

Medical & Dental Reimbursement Account
Dependent Care Reimbursement Account
Premium Reimbursement Account

Claim Form Instructions:

1) Copies of bills indicating date of service; provider name, patient name and charges must be enclosed with the Claim Form unless you are submitting an Explanation of benefits (EOB) statement from an insurance carrier.

2) 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.

3) All areas of the Claim Form must be completed for any claim to be processed.

4) If you have any questions, please call the Claims Administration Office at (315) 379-3000,
or write to: St. Lawrence-Lewis
Claims Administration Office
P.O. Box 697
Canton, NY 13617

Fill out the following information:

School District: _____

Employee Name: _____

Employee Social Security Number: _____

Employee Phone Number: _____

Employee Address: _____
(Street)

_____

_____
(City) (State) (Zip)

☐ (Please check here if address has changed)

	Date(s) 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)
☐ Med/Dent ☐ Dep Care ☐ Premium						
☐ Med/Dent ☐ Dep Care ☐ Premium						
☐ Med/Dent ☐ Dep Care ☐ Premium						
☐ Med/Dent ☐ Dep. Care ☐ Premium						

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)