IRS SECTION 125 FLEXIBLE SPENDING ACCOUNT
MEDICAL REIMBURSEMENT AND DEPENDENT CARE
CLAIM FORM

THIRD PARTY CLAIMS ADMINISTRATOR

COMBINED INSURANCE SERVICE (CIS), 814 East Silver Springs Blvd, Suite E, Ocala, FL 34470, (800) 473-2181.

- MEDICAL REIMBURSEMENT
  Attach a copy of the invoice/bill/receipt, etc., for reimbursement of your expenses. If the expense is covered under your insurance plan it should be submitted to your insurance carrier first. Once you receive your insurance statement, attach the statement to this form for reimbursement of your portion of the expenses.
- DEPENDENT CARE REIMBURSEMENT
  Attach a copy of your receipt for dependent care expenses showing who was paid, for what dependent, and for what dates. Qualifying dependents are children under the age of 13, a disabled spouse or other dependents who are physically or mentally incapable of self-care. Both you and your spouse must work or one must be a full-time student in order to file for dependent care expenses.
- DEADLINE FOR SUBMISSION OF CLAIMS
  All claims must be submitted for reimbursement by the 90th day following the Plan Year. **Claims submitted after this date will not be processed.**

CLAIM INFORMATION

Claims may be mailed to: Combined Insurance Services, Inc.
PO Box 2438
Ocala, Fl 34478

Claims may be faxed to: Claims Adjuster
(352) 237-2040

EMPLOYER:_____

EMPLOYEE:_____ **SOC. SEC. #:**_____ **DAYTIME PHONE**_____

TYPE OF CLAIM	DESCRIPTION	AMOUNT
DEPENDENT CARE:	Name of Dependent:_____ Period Covered: From_____ To_____ Service Provider:_____	$_____
MEDICAL:	Date of Service: _____	$_____

I certify that the above information is correct. I further certify that these expenses have not been previously reimbursed on this or any other benefit plan and will not be claimed as an income tax deduction. I am claiming reimbursement only for eligible plan participants and understand that the Flexible Spending Accounts are a provision of the IRS Section 125.

EMPLOYEE'S SIGNATURE:_____ **DATE:**