REQUEST FOR REIMBURSEMENT
USBA*flex* CLAIM FORM

860 East 9085 South
Sandy, Utah 84094
877-USBA125 * Fax 866-872-2125

Company Name:			
Employee Name:	Last First MI	**SS#**	
Address:	Street City State ZIP	**PHONE**	( )

☐ **Please check if this is a new address**

Please read the back of this form for Reimbursement Account Rules and Claim Filing Instructions before completing this claim.

* Information below must be completed. Provider's may sign the below affidavit to certify the amount and date of expenses incurred, if no receipt is available.

DEPENDENT CARE CLAIMS

Date of Service From	To	Dependent Name	Age	Dependent Care Provider Name	Dependent Care Provider Address	Provider Tax Id#/SS#	Claim Amount
							$
							$
							$
							$
							$
							$
							$
							$
							$
							$
							$
							$
							$
							$
						Total:	$

AFFIDAVIT OF DEPENDENT CARE SERVICES RENDERED

I have provided adult/child care for the above named dependent for those dates and expenses identified for reimbursement above.

Signature of Care Giver_____ Date_____/_____/_____

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature: _____ Date: _____ /_____ /_____