



Flexible Spending Account Reimbursement Claim Form

2600 West 49th Street
P.O. Box 7406
Sioux Falls, SD 57117-7406

FLEX

Phone: 1-800-325-5598
Fax: 1-605-336-0270

Employer _____
Employee Name _____
Phone _____

SS#/DKC Insurance ID _____
E-mail _____

Dependent Care Expense Claims

Name of Dependent(s)	Period Covered		Name, Address, and Taxpayer Identification Number of Provider of Service	Amount Incurred
	From	To		
<i>Provider's Signature:</i>				
Total Dependent Care Expense Claim *				

➔ Attach a receipt from your daycare provider, or include the daycare provider's signature.

*NOTE: The total amount claimed under the Plan for any coverage period must not exceed the lesser of your earned income for the Plan Year or the earned income of your spouse. (If your spouse is either a full-time student or is incapable of taking care of himself or herself, then he or she is deemed to have monthly earnings of \$250 if there is one (1) child or dependent, or \$500 if there are two (2) or more.) No payment may be made under the Plan; if the service provider is your dependent for federal income tax purposes; or if your child or stepchild and is under age 19.

Unreimbursed Medical Expense Claims

Date Expense Incurred	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount
➔ Attach appropriate receipt(s) and submit with this claim form.			Total Medical Care Expense Claim	

Read Carefully: The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the Company's Cafeteria Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

Employee's Signature

Date

How To File A Claim

When filing your claim, you must complete a Reimbursement Claim Form and attach one of the following acceptable documents/receipts. *Canceled checks, credit card slips, or statements showing only a balance due on your account* are not acceptable documents/receipts for reimbursement.

Medical, Dental, and Vision Claim Receipts

Explanation of Benefits from your insurance carrier

If expense is not covered by insurance, an itemized billing from your provider that states the following:

1. Service Type
2. Service Date
3. Amount you are responsible to pay for service

Over The Counter Receipts

Dated receipt with the expenses you want reimbursement for highlighted.

Daycare Receipts

Receipt from Daycare Provider that lists the dates of service

Daycare Provider's name, Tax ID Number, and signature on your Reimbursement Claim Form.

Remember to:

- 1. Keep a copy of the Reimbursement Claim Form and supporting documents for your records.***
- 2. Make sure you completed Employer, Employee Name, SS#/DKC Insurance ID fields on Reimbursement Claim Form.***

Where To Send Your Reimbursement Claim Form

Mail To: DAKOTACARE Flex
 2600 West 49th Street
 P.O. Box 7406
 Sioux Falls, SD 57117-7406

Fax To: DAKOTACARE Flex
 605-336-0270

Email To: flex@dakotacare.com