# Flexible Benefit Plan Claim Form

| ACCOUNT HOLDER INFORMATION: |
|---|
| Name of Employer: Stark County Schools COG |
| Employee Name: |
| Social Security Number: |
| Day Time Phone Number: |

**Please reimburse the following Medical and/or Dependent Care expenses as covered under the Flexible Spending Account Plan.**

**Dependent Care Flexible Spending Account Claims:**

| *Name of Dependent(s)* | *Period Covered* | *Name, Address, & Tax ID Number* | *Amount* |
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**Total Dependent Care Claim** $

**Flexible Spending Accounts:**

| *Date Expense Incurred* | *Name of Service Provider* | *Person For Whom Expense Incurred* | *Expense Description* | *Amount* |
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**Total Medical Claim** $

**A detailed receipt including the merchants name, date of purchase, product name and the amount paid for the item must accompany any claim.**

- You are responsible for determining the validity of each item to be reimbursed; it is not the responsibility of your Employer or the administration company.
- These items cannot be reimbursed under any other plan.
- Supporting documentation must be attached to validate all reimbursement requests.
- Documentation must be a copy of the bill, explanation of benefits (EOB) or receipt which provides date of service or date of purchase.
- For Over The Counter (OTC) expenses to be reimbursed you must submit a detailed receipt including the merchants name, date of purchase, product name and the amount paid for the item.
- Medical Care Expenses reimbursed by this Plan cannot be claimed as deductions on your personal income tax return.
- Child Care Expenses cannot be reimbursed in excess of $5,000 per year. Child care expenses reimbursed by this Plan cannot be claimed as a credit on your personal income tax return.

**Employee's Signature:** X _____ **Date:** _____

***Fax to: 216-642-4863***

***Mail to: Vantage Financial Group Flexible Benefits 6200 Rockside Road, Suite 100 P.O. Box 318082 Cleveland, OH 44131***