BAS Benefit Administrative Systems, LLC

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Flexible Spending Account – Debit Card Claim Form /Flex Claim Form

EMPLOYER NAME: CITY OF CARMEL

Employee Name: ______________________________ **SSN:** ____________________

Date Expense Occurred	Name of Service Provider	Expense Description	Person for Whom Expense Occurred	Net Amount

You must attach appropriate receipt(s) and submit with this claim form

☐ I do **NOT** need reimbursement for the attached receipts – I used my Flex Debit Card for the transaction.

☐ I **DO** need reimbursement from my flex account. The attached receipts were paid out of pocket.

☐ I would like to order an additional FLEX DEBIT card for my spouse.

Spouse's Name & Social Security Number ______________________________

☐ Comments / Question: ______________________________

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 understand that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is pro vided 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