FLEXIBLE SPENDING ACCOUNT CLAIM FORM

Please attach bills/receipts and return to Benemax, FSA Dept., P.O. Box 950, Medfield, MA 02052
Fax #: 508-242-6198 or via e-mail to: benemax.claims@onedigital.com ***Attn: FSA Claims***

Employee Name	*Social Security Number*
Date	*Employer Name*

Dependent Care ("Day Care") Expense Claims

Name Of Dependent(s)	Period Covered From	Period Covered To	Name, Address and Taxpayer Identification Number of Provider of Service	Amount Incurred
				$
				$
				$
			*TOTAL DEPENDENT CARE EXPENSE CLAIM	$

*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 $200 if there is one (1) child or dependent and $400 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 is your child or stepchild and is under age 19.

Unreimbursed Health Expense Claims

Date Expense Incurred	*Name of Service Provider*	*Expense* Description	Person for Whom Expense Incurred	Net Amount
				$
				$
				$
				$
				$
				$
				$
				$
		TOTAL MEDICAL CARE EXPENSE CLAIM		$

The undersigned Plan participant certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the Company's Flexible Spending Account Plan with respect to such expenses and that the medical expenses have not been reimbursed and are not reimbursable under any other health plan. 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 taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

Employee Signature X	*Date*