



Reimbursement Claim Form

Flexible Benefit Plan

Fax, Mail, or Email your claim form with substantiation:

Compensation Consultants, Ltd.
P.O. Box 720
Cloquet, MN 55720

Fax: 218-879-9684
Email: spw@ccflex.com

Employer Name:	
Employee Name:	Social Security Number:

Dependent Care Expense Claim			
Name of Dependent	Dates of Service From To	Name, Address & Taxpayer Identification Number of Service Provider	Amount Incurred
Attach a receipt from your daycare provider or include the Daycare Provider's Signature	Provider's Signature:		
	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 talking care of him/herself, then he/she is deemed to have monthly earnings of \$250 if there is (1) one child or dependent, or \$500 if there are (2) two 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 Medical Expense Claim				
Date Expense Incurred (mm/dd/yy)	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount
Attach appropriate substantiation and submit 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, and dependents by federal definition, was covered under the Employer'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/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 Signature:	Date:
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