Submit Claims to:
Gasconade Co. R-I Schools
ATTN: Susan Stiers
164 Blue Pride Drive
Hermann, MO 65041
Fax# 573-486-3032

***Note** Please keep originals for tax purposes. There is no need to forward originals

This is page _____ of _____(include claim form and supporting documentation)

Make copies of this form as necessary

FLEXIBLE BENEFITS CLAIM FORM

Employer:	
Employee Name:	Social Security Number:
Address:	City, State, Zip
Work Telephone: Home Telephone:	E-mail Address:

Health Care Reimbursement

Person for Whom Expense was Incurred	Expense Description	Date of Service*	Amount of Expense
Please attach appropriate receipts and submit with this Claim Form		**Total Amount:**	$

*Date of Service is the date the service was performed or the prescription was purchased. It is **NOT** the date you make the payment to the provider. To be reimbursed, a medical claim **MUST** be for a service performed within the Plan Year and while you are an eligible participant in the Plan.

Dependent Care Reimbursement

Name of Dependent(s)	Period Covered From	Period Covered To	Name, Address & Taxpayer ID# of Service Provider	Amount Incurred
Please attach a receipt from your daycare provider or include the daycare provider's signature			**Provider's Signature:**	
			Total Amount Incurred:	$

The dependent care account cannot be overdrafted. Additionally, only expenses incurred to date can be reimbursed.

Do not include amounts paid or eligible for payments under any other health care pan or program, deferral state, or governmental program, worker's compensation or any other policy of health insurance.

To the best of my knowledge and belief, my statements in this request for reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants. I certify that these expenses have not been preciously reimbursed under this or any other benefit plan and will not be claimed as an income tax deduction.

Employee Signature _____ **Date** _____