DIVERSIFIED BENEFIT SERVICES, INC.

Dedicated to Excellence in Benefit Management Solutions

125-FSA

Section 125 Flexible Spending Account (FSA) Claim Form

Mail or fax this form with documentation to:
Diversified Benefit Services, Inc.
P.O. Box 260
Hartland, WI 53029
Fax: (262) 367-5938
For additional claim forms log on at www.dbsbenefits.com

Participant Name (please print): ______________________________

Email Address: ____________________ **Participant ID Number or Social Security Number:** ____________

Name of Your Employer (please print): ______________________________

Employee Signature: ______________________________ **Date:** ____ / ____ / ____

Indicate here if your address/information has changed:

____

____

____

SECTION 125 FLEXIBLE SPENDING ACCOUNT (FSA)
SEE INSTRUCTION GUIDE IN REIMBURSEMENT KIT

Complete this section if you want reimbursement for care of a dependent that was provided by a childcare facility, adult dependent care center or individual.

CLAIM TYPE I: DEPENDENT CARE REIMBURSEMENT ACCOUNT

Amount of expense incurred: $______________________________

Name of dependent care provider: ______________________________

Social Security Number: ______________________________

OR Federal Tax ID number of dependent care provider: ____________________

Dates of Service **(within plan year)**: From: ____________ To: ____________

Signature of **(or attach receipt from)** dependent care provider: ____________________

OFFICE USE ONLY A: ____________ D: ____________

Complete this section if you want reimbursement for medical, dental, vision, etc. type expenses.

CLAIM TYPE II: MEDICAL REIMBURSEMENT ACCOUNT

Amount of expense incurred: $______________________________

Dates of Service: From: ____________ To: ____________

Check if for orthodontia (braces): ❐

You must attach proper documentation with dates of service, description and nature of expense and amount of out-of-pocket expense.

OFFICE USE ONLY A: ____________ D: ____________

Complete this section for independent insurance premiums (such as private medical and/or dental insurance, Medicare Part B).

CLAIM TYPE III: INDEPENDENT PREMIUM FEATURE

Amount of expense incurred: $______________________________

Premium billing period (within the plan year): From: ____________ To: ____________

You must attach a copy of the independent insurance premium billing. This is not for reimbursement of group insurance premiums paid through your employer.

OFFICE USE ONLY A: ____________ D: ____________

By signing this form, I certify that the amounts listed are correct and are expenses that represent qualified reimbursable expenses. I will not claim these items on my personal income tax return for medical itemization nor claim any dependent care reimbursement expenses as tax credit. I certify that I will not be reimbursed for the expenses listed below from any insurance company or insurance plan or the following: any other Flexible Benefit Plan, Medical Savings Account (MSA), Health Reimbursement Arrangement (HRA), Health Savings Account (HSA), another reimbursement plan or any other source. I also certify that the expenses have been incurred and dates of service are during the timeframe required by the benefit plan. I will also provide documentation necessary to support the amounts being requested for reimbursement. In addition, by signing this document, I acknowledge and agree that DBS may, in the case of an overpayment (fraudulent, inadvertent or otherwise), offset future expense reimbursements to me to account for such an overpayment. I also agree to immediately inform DBS if I become aware of an overpayment and agree to reimburse the Plan Sponsor to the extent that an offset of future reimbursements is either impossible or inconvenient. Finally, I certify that I am aware that I may be reimbursed from the Plan only for my own expenses, expenses of my spouse, and expenses of my "dependent" children as defined by my employer's Plan.