

North Georgia College and State University

Flexible Spending Account Claim Form

Health Care

Dependent

Attach all appropriate documentation, such as Explanation of Benefits from insurer, proof of co-payment from healthcare provider, prescription receipt or receipts for other expenses not covered by your insurance.

Employee Name					Social Security Number
Home Address					
City, State, ZIP Code				Insurance Carrier	
IF CLAIM IS FOR DEPENDENT (HEALTH CARE OR DEPENDENT CARE)					
1	DEPENDENT NAME	SOC SEC# for dependent care	DATE OF BIRTH	FULL-TIME STUDENT?	RELATIONSHIP
2	DEPENDENT NAME	SOC SEC# for dependent care	DATE OF BIRTH	FULL-TIME STUDENT?	RELATIONSHIP
3	DEPENDENT NAME	SOC SEC# for dependent care	DATE OF BIRTH	FULL-TIME STUDENT?	RELATIONSHIP
IF CLAIM IS FOR DEPENDENT CARE (leave blank if claim is for Health Care)					
1	PROVIDER OF SERVICE		FEDERAL ID #	ADDRESS	
	AMOUNT OF CHARGE		PERIOD OF SERVICE COVERED IN THIS CLAIM		
2	PROVIDER OF SERVICE		FEDERAL ID #	ADDRESS	
	AMOUNT OF CHARGE		PERIOD OF SERVICE COVERED IN THIS CLAIM		
3	PROVIDER OF SERVICE		FEDERAL ID #	ADDRESS	
	AMOUNT OF CHARGE		PERIOD OF SERVICE COVERED IN THIS CLAIM		
FOR ALL REIMBURSEMENT CLAIMS					
CALENDAR YEAR TO WHICH PAYMENTS APPLY			TOTAL AMOUNT REQUESTED FOR REIMBURSEMENT		
DATE			SIGNATURE OF EMPLOYEE		

By signing this form, I certify that the amounts listed are correct and are expenses that represent qualified reimbursable expenses as detailed in **North Georgia College and State University (NGCSU) Flexible Spending Account Combined Summary Plan**. I will not claim these items on my personal income tax return for medical itemization nor claim any dependent care reimbursement expenses as a tax credit. I certify that I will not be reimbursed for the expenses listed above from any insurance company or insurance plan. I also certify that the expenses have been incurred during the timeframe required by the plan. I have also provided documentation necessary to support the amounts being requested for reimbursement.