Flexible Spending Account Claim Form

Complete this form to receive reimbursement from your Flexible Spending Account. You MUST attach documentation and sign this form for prompt reimbursement.

Employee/Participant Information

Employee/ Participant Name | **Employee Social Security #**

Employer/ Company Name

☐ Change of Address **Home Address** | **City, State Zip**

** **Email Address** | **Contact Phone**

Expense Information

Date(s) Incurred	Type of Expense*				Description of Expense	Name of Family Member	Relationship to Employee	Expense Amount
	H	D**	P	T				
	☐	☐	☐	☐				$
	☐	☐	☐	☐				$
	☐	☐	☐	☐				$
	☐	☐	☐	☐				$
	☐	☐	☐	☐				$
	☐	☐	☐	☐				$
	☐	☐	☐	☐				$
	☐	☐	☐	☐				$
							Total	$

* H = Healthcare expense (Dental, Vision, Rx, etc.), D = Dependent care expense (day care), T = Transit
P = Parking

** You will need to complete a **Dependent Care Verification Form** for any dependent care expenses.

Authorization

The undersigned participant in the Plan 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 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 Dependent Flexible Spending Account is used for dependent care expenses that allow you (or you and your spouse if married) to work or look for work or that allow your spouse to attend school full time. The care may be provided inside or outside your home. For more details, please refer to your Summary Plan Description. 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 related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense. If a fraudulent claim is filed, you will be responsible for paying back the fraudulent claim.

Signature ☐ By checking the box to the left I agree to the above terms. **Date**

Print Name

Please fax this form and documentation to (866) 209-3517, e-mail to flex@swerdlin.net, or mail to Swerdlin & Company, 5901 Peachtree Dunwoody Road, B-170, Atlanta, GA 30328.
For questions, please call (866) 687-4015 or e-mail flex@swerdlin.net. For balance inquiries, visit www.swerdlin.net.
You must attach documentation for the above incurred expenses to this form.

**Please provide an Email Address if you would like to receive email notifications from Swerdlin, including notifications when we receive your claims.