**Sharyland ISD**

## *Flexible Spending Account Claim Form* — Unreimbursed Medical Expenses

**Employee Name** _____ (Last / First) **SS#** _____

**Employee Address** _____ (Street Address / City / State / Zip)

**How can we contact you?** _____ (Daytime Phone) _____ (Personal E-mail address (optional))

**For prompt claim service please make sure to:**

1) complete this form;
2) attach copies of itemized bills which indicate service date, provider, service, expense amount, and family member. Cancelled checks and credit card receipts alone are not sufficient.
3) attach copies of Explanation of Benefits from other benefit plans that cover these services;
4) sign the Claim Form below.

| Employee or Dep. | Date of Service | Provider | Type of Service | Amount Requested |
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| | | | Total Requested → | |

**Employee Certification:**

I certify that the expense(s) listed above were incurred by me or my eligible dependent and qualify for reimbursement, that reimbursement is not available from any other benefit plan and that I have not received any reimbursement from other sources for these expenses. I understand that all reimbursement received under this Plan will be paid directly to me and that I am responsible for any taxes or penalties that may arise in the event that I request and receive reimbursement that does not qualify for tax deductibility under federal or state law.

Employee Signature _____ Date _____

**Mail to:** Frates Benefit Administrators
13439 Broadway Extension, Suite 110
Oklahoma City, OK 73114
(405) 290-5696

**Fax to:** (405) 775-5992
Attention FLEX Claims

Frates Benefit Administrators

**URM**

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