

**FLEXIBLE SPENDING PLAN CLAIM FORM**

**Send Forms To:**

HUB International, N.E.  
 1393 Veterans Memorial Highway, Suite 210N, Hauppauge, NY 11788 – Attn. J. Miller  
**\*Please call Joanne Miller at 631-360-5308 or Phyllis Cox at 631-360-5309 with questions\***  
**Or you can fax your claim to 917-934-5316 or 917-934-5315**

Employer: Eden II School for Autistic Children, Inc.

Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone #: \_\_\_\_\_

**Unreimbursed Medical Expense Claims**

Date Expense Incurred	Name of Service Provider	Expense Description	Person For Whom Expense Was Incurred	Net Amount
<b>ATTACH REQUIRED DOCUMENTATION</b>			<b>Total Medical Care Expense Claim</b>	

**Dependent Care Expense Claims**

Name of Dependent(s)	Period From	Covered To	Name, Address and Taxpayer ID # of Provider of Service	Amount Incurred
<b>ATTACH REQUIRED DOCUMENTATION</b>			<b>*Total Dependent Care Expense Claim</b>	

\*Dependent Care Note: The total amount claimed under the Plan for any coverage period must not exceed the lesser of your earned income for the plan year or the earned income of your spouse. (If your spouse is either a full-time student or is incapable of taking care of himself or herself, then he or she is deemed to have monthly earnings of \$200 if there is (1) child or dependent, and \$400 if there are two (2) or more.) No payment may be made under the Plan if the service provider is your dependent for federal income tax purposes, or is your child or stepchild and is under age 19.

**READ CAREFULLY**

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 undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to the 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, FICA (Social Security) or city income tax on amounts paid from the Plan which relate to such expense.

\_\_\_\_\_  
 Employee's Signature

\_\_\_\_\_  
 Date