Benefit Plans Plus

Flexible Benefit plan Reimbursement Claim Form

Scan and email claim form and documentation to **flexplan@bpp401k.com OR**

Fax: 618.654.4624 **Mail**: 2220 S. State Route 157, Ste. 300, Glen Carbon, IL 62034

Employer

Name | Last 4 digits of SSN

Address | email

City | State | Zip Code | Phone

Dependent Care Expense Claims

Dependent Name	Period Covered From - To	Service Provider Name Tax ID	Service Provider Address	Amount Incurred

Provider's Signature*:

Total Dependent Care Expense Claim**

* Attach a receipt from your service provider, or include the provider's signature.

** 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 one (2) child or dependent, or $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 the age of 19.

Out-Of-Pocket Medical Expense Claims

Expense Date	Service Provider	Expense Desciption	Person for Whom Expenses Incurred	Net Amount	Dr. Note On File?
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					☐
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Attach appropriate receipt(s), note(s) and submit with this claim form

Total Medical Expense Claim

Read Carefully: The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided 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 this claim which is provided by the undersigned, and that unless and 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.

Signature | Date