

--PRINCIPIA FLEX SPENDING ACCOUNT CLAIM FORM--

**TO:** J. W. Terrill Benefit Administrators **ATTN:** Principia Flexible Spending Account Administrator

**FROM:** Principia employee (name) \_\_\_\_\_ SSN \_\_\_\_\_

**RE:** Flex spending account claim for payment

**FAX:** 636-728-7856 **No. of pages** \_\_\_\_\_

-- or mail to 16091 Swingley Ridge Road, Suite 200, Chesterfield, MO 63017

I hereby file this Flex Account claim as follows:

**a) HEALTH CARE CLAIM**

For expenses covered by any health plan, attach a copy of insurance Explanation of Benefits (EOB). For expenses NOT covered by insurance, attached a copy of appropriate bills. DO NOT include any amounts paid or eligible for payment under any other health care plan or program, federal, state or governmental program, worker's compensation or other policy of health insurance. Canceled checks and balance forward statements are NOT acceptable receipts.

Patient Name	Relationship	Date(s) of Service	Service Provided	Cost

**b) DEPENDENT (CHILD/ELDER) CARE CLAIM**

Attach a copy of the statement from the child/elder care provider, OR have the provider sign in the box below. The following information is REQUIRED: Provider's name, address, and taxpayer ID# (or S.S.#). Canceled checks are not acceptable receipts.

Dependent Name	Dependent Birth Date	Date(s) of Service	Relationship	Provider Name, Address, Taxpayer ID/Social Security #	Cost

Provider signature:

To the best of my knowledge and belief, my statements in this Request for Payment are complete and true. I am filing for payment only for eligible expenses incurred by me or my eligible dependents during the applicable plan year. I certify that these expenses have not been previously reimbursed under this or any other benefit plan, and will not be claimed as an income tax deduction.

Please send dependent care reimbursement to employee.

Name and address of employee:

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone: \_\_\_\_\_

Date \_\_\_\_\_

Employee Signature \_\_\_\_\_

# *The* PRINCIPIA

To: The Principia Community  
From: Human Resources Department  
Re: **FLEXIBLE SPENDING ACCOUNT CLAIM PROCESS**

Claims for payments from your dependent care or health care flex accounts are to be submitted to J. W. Terrill. **Please note that the claim form is on the reverse side of this page.**

**For payment of benefits in a flexible spending account** matter, fax a signed and fully completed claim form to J. W. Terrill at 636-728-7856. You may also mail any forms directly to J. W. Terrill at:

J. W. Terrill Benefit Administrators  
ATTN: Principia Flexible Spending Account Administrator  
16091 Swingley Ridge Road  
Suite 200  
Chesterfield, MO 63017

Toll free phone number: 800-279-7728

Please note:

- A signed, fully completed claim form must be submitted with each group of claims for reimbursement.
- You must indicate the dollar amounts for reimbursement from your FLEX PAY account(s).
- Expenses paid from your FLEX PAY reimbursement account(s) cannot be claimed as income tax deductions.
- You will receive an explanation of the claims paid and your remaining account balance(s) on your FLEX PAY reimbursement check stub.
- Canceled checks and balance forward statements are not acceptable receipts for either reimbursement account.

We will send further informational communications on the Flex Account Claim procedure as needed.