FLEXIBLE SPENDING ACCOUNT CLAIMS AFFIDAVIT

COMPANY ______________________________________

NAME ____

SOCIAL SECURITY # ____________________________

Please indicate the amount of the expenses you have incurred. Retain a copy for your records.

UNREIMBURSED MEDICAL, DENTAL, ETC. $ _____________________
(Included written statements substantiating the expenses claimed on this affidavit from all third party providers.)

CHILD AND DEPENDENT DAYCARE: $ ______________________

I HEREBY CERTIFY that this claims affidavit does not include any amounts that have been reimbursed or are reimbursable under any other health plan. I understand that the maximum amount of reimbursement under the health FSA has been available at all times; and any unused declarations at the end of the plan year will be forfeited. I further understand that I cannot deduct any expenses for which I am reimbursed on my individual Federal and State income tax returns.

SIGNED ___________________________________ **DATE** _____________________

EACH RECEIPT NEEDS:

1) DATE OF SERVICE
2) SERVICE RECEIVED
3) NAME OF CAREGIVER
4) COST OF SERVICE

SEND TO:

PETER ZAPPA & ASSOCIATES
P.O. BOX 2749
NORTH ATTLEBOROUGH, MA 02763
1-800-659-0527
FAX 1-508-285-4607

PLEASE ATTACH A **PHOTOCOPY** OF THE RECEIPT
CANCELLED CHECKS ARE **NOT** ACCEPTABLE RECEIPTS