Flexible Spending Account (FSA)

Page ___ of ___*(including this claim form)*

Reimbursement Claim Form

BASIC pacific

Employer: _____

FAX TO: (916) 303-7083 or (800) 584-4591
EMAIL TO: customerservice@BASICpacific.com

Employee Name: _____ Social Security Number: _____

Phone: _____ E-mail: _____

Dependent Care Expense Claims

Name & Date of Birth of Dependent(s)	Period Covered From	To	Name, Address, and Taxpayer Identification Number (or SSN) of Service Provider	Amount Incurred
☐ *Attach a receipt from your daycare provider, or include the daycare provider's signature.*			**Provider's Signature:**	
			Total Dependent Care Expense Claim*	**$**

*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 $250 if there is one (1) child or dependent, or $500 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.

Medical Expense Claims

Date Expense Incurred (mm/dd/yyyy)	Name of Service Provider	Expense Description (Medical, Dental, Vision, Rx, OTC, etc.)	Person for Whom Expense was Incurred	Net Amount
☐ *Attach appropriate receipt(s) and submit with this claim form.*			**Total Medical Care Expense Claim**	**$**

REQUIRED DOCUMENTATION: All claims must include "complete" – "third-party" documentation. "Complete" documentation must include the: (1) patient's name; (2) service provider's name; (3) full date of service (including year); (4) description of service; (5) charge or patient portion for the service. If you have insurance, your carrier must process your claim prior to being reimbursed from your FSA. An Explanation of Benefits (EOB) from your insurance carrier is considered "complete" documentation. "Third-party" means provided to you by your service provider (e.g. doctor, pharmacy, day care, etc.) or insurance carrier.

CERTIFICATION: The undersigned participant in the Plan certifies that all services for which reimbursement is claimed by submission of this form were provided during a period while the undersigned was covered under the Plan with respect to such expenses and that the expenses have not been reimbursed and employee will not seek reimbursement from any other plan covering health benefits or from any other source. 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 an expense for which reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes, including federal and state income tax, on amounts paid from the Plan which relate to such expense.

***DO NOT USE THIS FORM IF YOU HAVE FILED YOUR CLAIM ONLINE (or used your BASIC pacific Debit Card)**

_____ _____

Employee's Signature Date