



# 125-FSA

## Section 125 Flexible Spending Account (FSA) Claim Form

Mail or fax this form with documentation to:  
Diversified Benefit Services, Inc.  
P.O. Box 260  
Hartland, WI 53029  
Fax: (262) 367-5938  
For additional claim forms log on at [www.dbsbenefits.com](http://www.dbsbenefits.com)

**Indicate here if your address/information has changed:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Participant Name (please print): \_\_\_\_\_

Email Address: \_\_\_\_\_ Last four digits of SS# \_\_\_\_ \_

Name of Your Employer (please print): \_\_\_\_\_

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**SECTION 125 FLEXIBLE SPENDING ACCOUNT (FSA)  
SEE INSTRUCTION GUIDE IN REIMBURSEMENT KIT**

Complete this section if you want reimbursement for care of a dependent that was provided by a childcare facility, adult dependent care center or individual.

**CLAIM TYPE I: DEPENDENT CARE REIMBURSEMENT ACCOUNT**

Amount of expense incurred: \$ \_\_\_\_\_

Name of dependent care provider: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

OR Federal Tax ID number of dependent care provider: \_\_\_\_\_

Dates of Service (within plan year): From: \_\_\_\_\_ To: \_\_\_\_\_

Signature of (or attach receipt from) dependent care provider: \_\_\_\_\_

OFFICE USE ONLY A: \_\_\_\_\_ D: \_\_\_\_\_

Complete this section if you want reimbursement for medical, dental, vision, etc. type expenses.

**CLAIM TYPE II: MEDICAL REIMBURSEMENT ACCOUNT**

Amount of expense incurred: \$ \_\_\_\_\_

Dates of Service: From: \_\_\_\_\_ To: \_\_\_\_\_

Check if for orthodontia (braces):

**You must attach proper documentation with dates of service, description and nature of expense and amount of out-of-pocket expense.**

OFFICE USE ONLY A: \_\_\_\_\_ D: \_\_\_\_\_

Complete this section for independent insurance premiums (such as private dental and/or vision insurance, Medicare Part B & D).

**CLAIM TYPE III: INDEPENDENT PREMIUM FEATURE**

Amount of expense incurred: \$ \_\_\_\_\_

Premium billing period (within the plan year): From: \_\_\_\_\_ To: \_\_\_\_\_

**You must attach a copy of the independent insurance premium billing. This not for reimbursement of group insurance premiums paid through your employer or any type of individual health premium.**

OFFICE USE ONLY A: \_\_\_\_\_ D: \_\_\_\_\_

By signing this form, I certify that the amounts listed are correct and are expenses that represent qualified reimbursable expenses. I will not claim these items on my personal income tax return for medical itemization nor claim any dependent care reimbursement expenses as tax credit. I certify that I will not be reimbursed for the expenses listed below from any insurance company or insurance plan or the following: any other Flexible Benefit Plan, Medical Savings Account (MSA), Health Reimbursement Arrangement (HRA), Health Savings Account (HSA), another reimbursement plan or any other source. I also certify that the expenses have been incurred and dates of service are during the timeframe required by the benefit plan. I will also provide documentation necessary to support the amounts being requested for reimbursement. In addition, by signing this document, I acknowledge and agree that DBS may, in the case of an overpayment (fraudulent, inadvertent or otherwise), offset future expense reimbursements to me to account for such an overpayment. I also agree to immediately inform DBS if I become aware of an overpayment and agree to reimburse the Plan Sponsor to the extent that an offset of future reimbursements is either impossible or inconvenient. Finally, I certify that I am aware that I may be reimbursed from the Plan only for my own expenses, expenses of my spouse, and expenses of my "dependent" children as defined by my employer's Plan.