Mail or Fax this form with documentation to:
2601 N. W. Expressway, Suite 1000-W, Oklahoma City, OK 73112
Telephone Number: (405) 840-3033 Toll Free: 1 (888) 840-8924
Fax Number: (405) 858-7343 Website: www.cabainc.com

FLEXIBLE SPENDING ACCOUNT CLAIM FORM

Employee Name (Please Print):	**Employer Name:**
Employee Social Security Number:	**Telephone Number:**

Please complete the information below. Place each expense on a separate line. Services must be incurred (services actually rendered) prior to reimbursement. The Internal Revenue Service requires that documentation from your provider or insurance company be submitted with each claim. Itemized receipts/statements or a copy of the Explanation of Benefits (EOB) from your insurance company must be submitted with this claim form. The documentation must provide the date of service, a description of the service provided and the charge for the service. Cancelled checks, received on account or any type of payment receipt/statement not showing the required information will not be considered eligible documentation. If eligible documentation is not provided, your claim will be returned unpaid asking for additional documentation.

DATE OF SERVICE	**PROVIDER**	**TYPE OF SERVICE** (Please provide a brief description of service. ex. medical, dental, orthodontia, vision, prescription, daycare/childcare)	**AMOUNT INCURRED OR PAID**	**CABA USE ONLY**

If claiming daycare/dependent care expenses, please complete the following (must be completed):

Dependent Care Provider Name:	**Provider Address:**	**Provider Tax ID Number or Social Security Number:**

I certify the above expenses were incurred by me and/or my eligible dependents. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year. The medical expenses indicated above have not been reimbursed under this or any other health plan nor are they reimbursable by any other health plan. These expenses will not be claimed as an income tax deduction. I understand these expenses will not be reimbursed without proper documentation.

I have examined this affidavit for errors and to the best of my knowledge and belief, it is true, correct and complete.

Any person who knowingly files a statement of claim containing any false, incomplete, or misleading information with intent to defraud or deceive may be guilty of a criminal act punishable by law.

Employee Signature **Date**