



## Recurring Claim Form

A recurring claim streamlines the reimbursement of qualified expenses by allowing you to automate claims if you make fixed payments to a service provider. This method of reimbursement cannot be used if your payments fluctuate or change during the course of the plan year.

Claims will be processed, while you are an active participant, until the Service End Date indicated below, or the last day of the plan year. Reimbursements will be issued based on your employer's preset reimbursement schedule.

This form is intended to act as the third-party substantiation required for claim reimbursement. You are still responsible for obtaining and retaining documentation for expenses reimbursed using this method. Please do not submit manual claims for the expenses detailed below.

### Employee Information

<b>Last Name, First Name</b>	<b>SSN / Employee ID #</b>
<b>Employer Name</b>	<b>Email Address</b>
<b>Mailing Address</b>	

### Recurring Claim Information

<b>Service Provider Name</b>	<b>Type of Service</b>	<b>For Whom</b>
<b>Provider Tax ID and/or SSN (for day care only)</b>	<b>Dependent Name and Age (for day care only)</b>	
<b>Dates of Service (must be within current Plan Year)</b> ____/____/____ through ____/____/____	<b>Scheduled Payments</b> \$_____      ___ Weekly ___ Monthly	
<b>The above information is true and correct.</b>		
_____	_____	
<b>Provider Signature (required for day care)</b>	<b>Date</b>	
<b>Please note:</b> for orthodontia & gym memberships, a contract from your service provider can be submitted in addition to this form, in lieu of a provider signature.		

### Employee Authorization

I hereby certify, understand and agree that I make fixed regular payments to my provider as detailed on this form. I am solely responsible for the sufficiency, accuracy, and veracity of the information related to this form and if payment is made for an improper expense or changes occur such that reimbursement is no longer proper I may be liable for the payment of all related taxes including federal, state or city income tax. I authorize my employer to take any and all steps necessary, including garnishing my wages, to make any corrections under this benefit. I am claiming expenses incurred by myself or my qualified dependents as defined by the IRS during the plan year and certify that these expenses have not been reimbursed under this plan or by any other source. I am responsible for keeping all substantiation or documentation in the event of an audit and I further understand it is my responsibility to obtain and report to the IRS the identification of my day care provider(s) when I file my taxes.

Participant's Signature <b>X</b>	Date
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