Spending Account Claim Form

Auxiant® Your Integrated Benefits Partner

This request is for reimbursement of:

☐ Medical Care Expenses (Complete parts A, B, and D)

☐ Dependent Care Expenses (Complete C and D)

☐ **MARK IF CHANGE OF ADDRESS**

Name		Member ID	
Address		City , State Zip	
Employer	**City of Fond du Lac**	Date Submitted	

A. MEDICAL EXPENSE INFORMATION

1. TOTAL DEDUCTIBLES, COINSURANCE and COPAYS (attached Explanation of Benefits): _____

2. OTHER EXPENSES (attach bills, statements, or other evidence of these expenses) *

DATE OF SERVICE	VENDOR NAME:	PATIENT NAME:	TYPE OF SERVICE PROVIDED	AMOUNT
**** Canceled check is not sufficient evidence***			Total other expenses	

3. TOTAL EXPENSES (1) + (2) = _____

B. SPOUSE AND DEPENDENT INFORMATION * (If expenses were for your spouse or dependent)

Name	*Date of Birth*	*Relationship*

* Your spouse is the person to whom you were married at the end of the Calendar year. Your dependents are your child, Step child, parent, other close relative, or a person who lives in your home, if you provide over half of his/her support, and they are claimed as a dependent on your Federal Tax Return.

C. DEPENDENT CARE (CHILD CARE) INFORMATION (*Required unless provider is non-profit organization)*

DEPENDENT NAME**	AGE	DATES OF SERVICE	PROVIDER NAME and ADDRESS	PROVIDER'S TIN or SSN	REQUESTED AMOUNT

Signature of Daycare Provider _____

**Care for Dependent Children under the age of 13 are eligible for Dependent Care reimbursement, unless *Special Rules* apply.

D. MEMBER SIGNATURE REQUIRED

I certify that the expenses listed above qualify for reimbursement and have been incurred by eligible members of my family. These expenses have not been reimbursed by my health care plan or any other health care plan such as my spouse's. Bills, statements or other evidence of these expenses are attached. In claiming reimbursement for dependent care expense, I understand the reimbursements may not exceed the lesser of:(a) $5,000 if married filing joint return or head of household or $2,500 if single or married filing separate returns; or (b) your taxable compensation; or (c) your spouse's actual or deemed earned income. I certify that if single or married, (my spouse and I) will not receive reimbursements in excess of allowable limit.

Signature_____ Date _____

Send Claims to: ATTN: Flex
AUXIANT, P.O. Box 75008, Cedar Rapids, IA 52407-5008
PHONE: (319) 398-3283 or (800) 475-2232 Fax (319) 739-1109