"Plaza Towers Building"
1736 E. Sunshine Ste 200
Springfield, MO. 65804
417-883-8088 or 800-995-3569
FAX: 417-883-8261
www.gbs-tpa.com

Cooper County Government

Flexible Benefit Plan Claim Form

Employee Name (Last, First, M.I.) :			
Address:			
City:	State:	Zip:	SSN:

Directions for using the Claim Form. **(This form should be copied for future use.)**
For each item you are requesting reimbursement, please attach documentation listing service dates, description, and charge. Cancelled checks or credit card receipts /statements are not valid forms of documentation. Complete the claim form, sign and date. Mail or fax to GBS "Attn: Claims". Unsigned claim forms cannot be processed.

Dependent Care Assistance

Dependent care expenses must be for a dependent that is incapable of self-care, or under the age of 13 at the time care was provided.

Name of Dependent	Age	Dates Care Provided From	To	Provider Name, Address, & Tax ID	Cost for Care Period
				Total:	

I provided dependent care as stated above. ______________________ __________ __________
Care provider's signature Date Tax ID#

Health Reimbursements.

Date	Provider Name	Description/Type of Service	Patient Name	Relationship	Dollar Amount
				Total:	

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under his/her employer's Flexible Spending Plan with respect to such expenses and that the expenses have not been reimbursed and reimbursement will not be sought from any other source. Any Dependent Care Assistance expenses claimed here were provided for my dependent under the age of 13 or for dependent that is incapable of self-care. 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 payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan which relate to such expense. **Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator or plan service provider, files a statement of claim containing false incomplete or misleading information may be guilty of a criminal act punishable under law.**

Signature: ____Date:______________________