



Medical/Dependent Care Reimbursement Program Claim Form

Please type or print in black ink. Questions? Call our Customer Service Center at 888-662-3646.

For faster processing, use our toll free fax: 866-477-6526

1. Personal Information

Social Security Number _____

Name of Employee (First) _____ (MI) _____ (Last) _____

Address _____

City _____

State _____ Zip Code _____

Phone Number (for confidential calls between 8:00am and 6:00pm CST) _____

Employer Name _____

2. Type of Claim

Medical Expense Reimbursement

Requested Amount: \$ _____

Dependent Care Reimbursement

Requested Amount: \$ _____

Please complete worksheet on the back of this form to itemize expenses and attach original receipts. Reimbursement requests must be at least \$25.00 unless the balance remaining is less.

3. Direct Deposit Payment Option

Select this option if you wish to have payments from Security Benefit made by **direct deposit** to your bank account.

Note: If this is the first time you are selecting this option – you must attach a void check below, which includes your financial institution's routing number and address.

I hereby authorize Security Benefit to initiate credit entries to my:

Checking Account Void Check Below Savings Account Account Information Below

Receipt by said bank of such credit entries shall be deemed receipt by me.

This authority is to remain in full force and effect until Security Benefit has received written notice from me of its termination in such time and in such manner as to afford Security Benefit a reasonable opportunity to act.

4. Signatures

This is to certify that I have incurred expenses that qualify for reimbursement under my employer's Security Benefit Medical/Dependent Care Reimbursement Program. None of these expenses have previously been submitted.

I certify that these expenses will not be paid or reimbursed by any insurance company or from any other source or I may be subject to IRS fines and/or penalties of perjury. I hereby request reimbursement for these expenses to the extent allowable. I understand that at the end of the plan year all unpaid claims (even if less than \$25.00) will be reimbursed in full and that any remaining fund balances at the end of the plan year will be forfeited to my employer.

Note: Claim form must be signed or it will be returned.

X _____
Signature of Employee

Date Signed

John A. Sample
123 Same Street
Anywhers, USA 12345 0001

Pay To The Order Of _____ \$ _____

For _____ DOLLARS

Tape Your Void Check Here!
(DO NOT STAPLE)

VOID

1123456789112233582492 0001

Savings Account Information

Transit Routing # _____

Account # _____

