Pro-Claim Plus, Inc.
Flexible Spending Account
Claim Form

Employer:__**Bethel College**______________________________ **CLAIM FOR REIMBURSEMENT**

Name:____________________________ SS #________________________ E-Mail Address____________________

DEPENDENT CARE EXPENSE CLAIMS

Name of Dependent(s)	Period Covered		Name,Address and Taxpayer Identification Number of Provider of Services	Amount Incurred
	From	To		
			Total Dependent Care Expense Claim	

UNREIMBURSED MEDICAL EXPENSE CLAIMS

Date Expense Incurred	Name of Provider	Expense Description	Person for Whom Expense was Incurred	Net Amount
			Total Medical Care Expense Claim	

Read Carefully

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 the Company's Cafeteria Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. 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 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 city income tax on amounts paid from the Plan which relate to such expense.

Employee's Signature____ Date________________

Mail All Claims To:

Pro-Claim Plus, Inc.
P.O. Box 9648
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Ph: 260-436-9495 x 303
E-Mail: mford@proclaimplus.com