Request for Reimbursement Claim Form

DataPath Administrative Services

Employer Name (Please Print) _____

Employee Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____ Zip _____

Social Security Number _____ Home Phone (____)_____ Work Phone (____)_____

Employee Email Address (if any)_____

☐ Please check if new mailing address ☐ Please check if new email address

Dependent Care Claims

Please read the Reimbursement Account Rules and Claim Filing Instructions before completing this claim. Use a copy of this form if you need more space. All information below must be completed.

Service Period From To	Dependent Name	Age	Provider Name	Provider Address	Provider Tax ID#/SS#	Amount
						$
						$
						$
						$
						$
						$
						$
						$
						$
						$
						$
						$
						$
					Total	$

Employee's Certification for Disbursement

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return. **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.**

Employee's Signature _____ **Date** _____/_____/_____
mm/dd/yy

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For fastest response, please FAX or EMAIL your forms.