L.R. Webber Associates
FSA/DCAP CLAIM FORM

Employer Name: _____

Social Security No.:_____

Participant's Name:_____
Last First Middle

The undersigned participant in the plan requests reimbursement in the amounts shown below: (If additional space is needed, please use the attached sheet.)

NOTE: Federal law requires that you submit a written statement (such as an itemized bill from the benefit provider) as well as proof that the claim is not being reimbursed by an Insurance Company. Also, you will not be entitled to claim this expense as a tax deduction.

Date Incurred	Name of Service Provider	Describe Expense	Person for Whom Expense Incurred	Choose Plan Type FSA/DCAP	Net Amount
TOTAL CLAIM AMOUNT					**$**

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 employers Flexible Benefits Plan or Dependent Care Account Reimbursement Plan with respect to such expenses and that such 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 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 the payment of all related taxes including federal, state or city income tax on amounts paid from the plan which relate to such expense. The undersigned further understands that no medical expense tax deduction or credit is permitted for amounts for which reimbursement is made.

_____ Date_____
Employee's signature

Phone Number:_____

Submit Claim To:

Mail: L.R. Webber PO Box 593 Hollidaysburg, PA 16648 **Fax**: 814-317-1610 **Email**: Claims@lrwebber.com