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FLEXIBLE SPENDING ACCOUNT PLAN

Claim form for **Dependent Care or Un-Reimbursed Medical Expenses**

PROCEDURE FOR FILING:

1. COMPLETE THIS CLAIM FORM TO PROVIDE INFORMATION (*Request for reimbursement Should be done monthly*)
2. ATTACH AN ITEMIZED PAID RECEIPTS SIGNED BY PROVIDER.

EMPLOYER/SPONSOR NAME: Yavapai Combined Trust

EMPLOYEE/MEMBER NAME: _____

MEDICAL ID/CERT #: _____ PHONE# _____

STREET ADDRESS: _____

CITY/STATE/ZIP CODE: _____

I AM FILING THE FOLLOWING EXPENSES FOR REIMBURSEMENT FROM MY DEPENDENT CARE OR UN-REIMBURSED MEDICAL EXPENSE FLEXIBLE SPENDING ACCOUNT:

PROVIDER NAME:		
PROVIDER ADDRESS:		
PROVIDER SS NUMBER OR FED TAX ID:		
SERVICES FROM:	TO:	\$
SERVICES FROM:	TO:	\$
SERVICES FROM	TO:	\$
TOTAL		\$

I CERTIFY, UNDER PENALTY OF PERJURY, THE ITEM(S) ATTACHED ARE TRUE AND CORRECT, AND THAT THE AMOUNTS REQUESTED ARE FOR CLAIMS INCURRED AND PAID BY ME (AND/OR MY ELIGIBLE DEPENDENTS). I ACCEPT RESPONSIBILITY FOR THE PROPER TREATMENT OF BENEFITS PAID UNDER THE PLAN WITH RESPECT TO ALL INDIVIDUAL INCOME TAX REPORTING AND VERIFY THE CLAIM IS FOR EXPENSES NOT REIMBURSED BY ANY OTHER PLAN.

MEMBER SIGNATURE: _____ DATE: _____

MAIL THIS FORM AND ORIGINAL RECEIPTS TO:



P.O. Box 25160
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Or email form/receipts to: Flex@summit-inc.net