City of Stamford Dependent Expense Claim Form

Mail Claim Form to:
City of Stamford Flexible Reimbursement Program
PO BOX 5817
Wallingford, CT 06492
Tel: (800) 446-8646

Social Security No.: _____ - _____ - _____

Participant's Name: _____
Last First Middle

The undersigned Participant in the Plan requests reimbursement in the amounts shown below:

Date Incurred	Name of Service Provider	Describe Expense	Person for Whom Expense Incurred	Net Amount
_____	_____	_____	_____	$_____
_____	_____	_____	_____	$_____
_____	_____	_____	_____	$_____
_____	_____	_____	_____	$_____
_____	_____	_____	_____	$_____
			Total Amount of Medical Expense	**$_____**

Note: Federal law requires that you submit a written statement (such as an itemized bill from the service provider – or an Explanation of Benefits from your insurance carrier which would show the amount billed by your provider and the amount paid (or not paid) by your insurance company) 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.

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 Tax Savings Plan with respect to such expenses and that such expenses have not been reimbursed, or are not reimbursable, under the 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, and 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.

_____ _____
Employee Signature Date