Mail to:
Claims Processing
Advantek Benefit Administrators
1180 E. Shaw, Suite 101
Fresno, CA 93710

or Fax to:
(559) 228-5460

Scan/Email: FSA@Advantekbenefit.com

FLEXIBLE BENEFITS PLAN CLAIM FOR REIMBURSEMENT

(For Dependent Care Reimbursment Only)

For Assistance Call: (866) 556-7655
Or email: FSA@Advantekbenefit.com

EMPLOYER	
EMPLOYEE NAME	MEMBER # or LAST FOUR DIGITS OF SS#

PLEASE INCLUDE THIS FORM WHEN SUBMITTING DEPENDENT CARE EXPENSES

DATE(S) SERVICES INCURRED	NAME OF DAY CARE PROVIDER	PERSON FOR WHOM EXPENSE INCURRED	NET AMOUNT
		TOTAL	

READ CAREFULLY

I certify that all expenses claimed on this form were incurred during a period while I was covered under the Company's Flexible Spending Plan and the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. I understand that I am responsible for the accuracy, and truthfullness of all information relating to this claim. I understand that unless an expense claimed is a proper expense under the Plan, I 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.

PLEASE INCLUDE RECEIPTS FOR REVIEW - SEPARATE FORM FOR EACH PLAN YEAR

EMPLOYEE SIGNATURE	DATE
X	