



**RECURRING CLAIM FORM**

**EMPLOYER:** \_\_\_\_\_

**DATE OF SUBMISSION:** \_\_\_\_\_

**Instructions:** Complete all information and have the form signed by your provider. Complete a new form if rates change or you begin using a different provider.  
**A completed form needs to be submitted for new plan periods.**

<b>EMPLOYEE NAME:</b>	<input type="text"/>	
<b>Social Security Number:</b>	<input type="text"/>	
	Dependent Name: <input type="text"/>	
	Dependent DOB: <input type="text"/>	
The provider charges a set amount of \$ <input type="text"/> per:		
<input type="radio"/> Week <input type="radio"/> Bi-weekly <input type="radio"/> Monthly <input type="radio"/> Hour <input type="radio"/> Other <input type="text"/>		
Rates are effective for	<input type="text"/>	to <input type="text"/>
Providers Name (print)	<input type="text"/>	
Tax ID #	<input type="text"/>	
Providers Address (required or claim will be denied): <input type="text"/>		

**Providers Signature:** \_\_\_\_\_

I certify that I have incurred the expenses for which reimbursement is claimed from the Flexible Spending Account and I further attest that I have not and will not claim credit for these exemptions on my individual income tax returns. I further certify that the above expenses are for the care of qualifying individuals. If an expense for which I am reimbursed is later disallowed by the Internal Revenue Service, I understand that I will be liable for payment of any related income or payroll taxes relating to such improper expense reimbursement. I fully understand that I am responsible for the sufficiency, accuracy and veracity of the information relating to this claim.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Email Address** \_\_\_\_\_

Please send claim form to: • [PRNS125@phillipsresource.com](mailto:PRNS125@phillipsresource.com) •