Flexible Spending Claim Form

Claims must be incurred during the Plan Year of Contribution

Name:______________________________ Social Security Number:_______ - _____ - __________

Health Care Request

You must complete the section below and attach a copy of the provider's bill or insurance company's "Explanation of Benefits" verifying the date of service, type of service, name of person receiving service, and the cost.

Date	Type	For Whom	Relationship	Cost
				$
				$
				$
				$

Total Health Care amount Requested (Amount that is your responsibility) $__________

Dependent Day Care Request

You must complete the section below and attach a copy of the provider's bill or a receipt verifying the name of the care provider, the provider's Tax I.D. or Social Security Number and signature, the date(s) of service and the cost, for **ALL** requests.

Dates	Provider's Name	Tax I.D. or Soc. Sec. #	For Whom	Cost
-				$
-				$
-				$

Total Dependent Care amount Requested $__________

To the best of my knowledge and belief, my statements on this request for Reimbursement are complete and true. I understand that I am solely responsible for the validity of claims submitted to my Flexible Spending Account. I am claiming reimbursement only for eligible expenses incurred by myself, spouse and/or dependents during the plan year shown above and certify that these expenses have not been reimbursed under this plan or by any other source and that they will not be reimbursed by any other source or insurance. Any Dependent Care Assistance expenses claimed here were provided for my dependent under 13 or for a dependent who incapable of care.

I herby authorize my Flexible Spending Account to be reduced by the amount(s) shown above.

Participants Signature ______________________________ Date__________________

For assistance please call the benefits department at 225-766-2622 or 1-800-535-7206.

Send this form and documentation to:
ESS
Benefits Dept.
8530 Anselmo Lane
Baton Rouge, LA 70810
or
Fax 225-761-1002