APA Benefits Inc.

Attach Receipts for ALL Items you are claiming.

Claim For Reimbursement

Employer _____ Social Security # _____

Name _____ Email Address _____

Dependent Care Expense Claims

	Name of Dependents	Period Covered		Name, Address and Taxpayer Identification Number of Provider of Service	Amount Incurred
		From	To		
1					
2					
3					
4					
5					
6					
7					
				TOTAL DEPENDENT CARE EXPENSE CLAIM	$

*NOTE: The total amount claimed under the Plan for any coverage period must not exceed the lesser of your earned income for the plan year or the earned income of your spouse. (If your spouse is either a full-time student or is incapable of taking care of himself or herself, then he or she is deemed to have monthly earnings of $200 if there is one (1) child or dependent, and $400 if there are two (2) or more). No payment may be made under the Plan if the service provider is your dependent for federal income tax purposes, or is your child or stepchild and is under age 19.

Unreimbursed Medical Expense Claims

	Date Expense Incurred	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
			TOTAL MEDICAL CARE EXPENSE CLAIM		$

READ CAREFULLY

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 Company's Flexible Spending Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other 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, the undersigned 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.

_____ _____

Employee's Signature Date

Fax to: Claim's Department 801.561.5056

Or Mail to: APA Benefits, Inc.
8899 South 700 East, Suite 225
Sandy, UT 84070