Medical / Dependent Care Claim

AMERICAN MUTUAL BENEFITS

2510 Warren Ave. Ste. 3350
Cheyenne, Wy 82001
Bus: 888.884.4080
Fax: 888.884.4085
amb@ambnow.com

Fax to 888.884.4085. Photocopy receipts on 8.5 x 11 paper. **DO NOT** submit original receipts.

Employee Name (first, mi, last) Social Security Number

Employer Name

Home Address

City State Zip

Telephone number Mark if change of address

Date of Expense	Provider	Expense Description	Family Member	Amount
			TOTAL	

Dependent Care Expense Claims

Dependent's Name	Period Covered From	Period Covered To	Name of Care Provider	Amount
			TOTAL	

The total amount amount claimed under Dependent Care 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 themself, then they are deemed to have a monthly earnings of $250 if there is one (1) child or dependent, and $500 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 the age of 19.

Required Documentation: Any receipt or proof of payment must have the name of the service provider, the date or range of dates of service, a description of service provided, the name of the person receiving the service and the cost of the service. **Credit card receipts and cancelled checks are not acceptable proof of service.**

Over-the-counter drugs and treatments: A receipt or documentation from the store is required with the name of the drug printed on the receipt. The store must provide this information, you cannot write it on the receipt. In addition you must provide information of the existing or imminent medical condition on the receipt, claim form, or on a separate statement for this purchase.

Medical equipment, vitamins, herbs, nutritional supplements, health club memberships, weight-loss programs, massage therapy, and purchases or services normally deemed cosmetic: To file a claim for these items, you must have a written statement from your physician stating the nature of your medical condition, the specific serivce or item needed and a statement that the service or item is needed for the treatment of your condition. Said statements must be renewed annually.

Employee Statement of Certification - Please read carefully and sign below.

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 Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other plan of coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to his/her claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under a Section 125 Cafeteria Plan, the undersigned may be liable for payment of all related taxes including federal, state, and city income taxes and penalties on amounts paid from the Plan which relate to such expense.

Employee Signature - Signature & Date *required* for claim to be processed. **Date**