



EMPLOYER NAME _____
MEDICAL AND DEPENDENT CARE EXPENSE ACCOUNT
REIMBURSEMENT REQUEST FORM

Name	SS#	Submit claims to: CieloStar 730 Second Ave. So. - Suite 530 Minneapolis, MN 55402 Phone 612-436-2778 Toll-free 877-491-5979 Toll-free fax: 877-491-6016 Local fax 612-335-9217 Email: flex@cielostar.com
Home Address	Address Change <input type="checkbox"/> Yes <input type="checkbox"/> No	
City	State Zip	
Phone: Work Home	e-mail:	

Complete the information below for expenses incurred by you, or any eligible dependents for which you request reimbursement. You must provide itemized receipts or other evidence illustrating that the expense was incurred. Be sure to provide all information requested on this form. If the form is incomplete your claim will not be processed and this form will be returned to you. Print or type the information requested, then sign and date the form.

HCRA					
MEDICAL EXPENSES (Medical, Dental, Vision)					
	Provider of Service (Doctor, dentist, pharmacy, etc.)	Person Receiving Service (Name and SSN)	Dates of Service (MO/DAY/YR)	Amount of Expense Claimed	Nature of Expense
1				\$	
2				\$	
3				\$	
4				\$	

DCRA						
DEPENDENT CARE EXPENSES (if necessary, attach additional sheets)						
	Provider of Service	Person Receiving Service (Name and SSN)	Age of Dependent	Dates of Service (MO/DAY/YR)	Amount of Expense Claimed	Provider Tax I.D. Number (Social Security Number if Individual)
1					\$	
2					\$	
3					\$	

Dependent Care Provider's Signature (if individual) _____

I hereby request reimbursement from my applicable flexible spending account(s), pursuant to the plan and applicable law, for the expenses listed above. I hereby represent and certify that the above expenses have actually been incurred and that these expenses have not and will not be reimbursed by any benefit plan and will not be claimed as an itemized income tax deduction.

Employee Signature _____ Date _____

PLEASE SEE REVERSE SIDE FOR FILING INSTRUCTIONS

INSTRUCTIONS FOR COMPLETION OF FLEXIBLE SPENDING CLAIM FORMS

HCRA

HEALTH CARE EXPENSES (Medical, Dental, Vision)

- Complete claim form – all requested information must be provided or claim will be denied.
- Attach originals or copies of medical bills, insurance explanation of benefits, prescription drug receipts, cash register receipts, etc. The documentation must provide the following information or the claim will be denied:
 1. Name of provider of service (doctor, dentist, pharmacy, etc.)
 2. Name of person receiving service (self, spouse, dependent)
 3. Date of service
 4. Explanation of procedure
 5. Cost of procedure less any amounts paid by primary insurance provider
- Mail or fax claim and expense documentation to:
 - CieloStar
 - 730 Second Ave. So., Suite 530
 - Minneapolis, MN 55402
 - Fax (877) 491-6016
 - Or (612) 335-9217
 - flex@cielostar.com

DCRA

DEPENDENT DAY CARE EXPENSES

- Complete claim form – all requested information must be provided or claims will be denied.
- Attach originals or copies of daycare invoices or payment receipts issued by daycare provider. The documentation must provide the following information or the claim will be denied:
 1. Name of daycare provider
 2. Tax ID number or social security number of provider
 3. Name of dependent receiving daycare service
 4. Dates of service
 5. Cost of service
- Mail or fax claim and expense documentation to:
 - CieloStar
 - 730 Second Ave. So., Suite 530
 - Minneapolis, MN 55402
 - Fax (877) 491-6016
 - Or (612) 335-9217
 - flex@cielostar.com