Fax or mail Claim Form and receipts to:
Citizens Bank & Trust - Cafeteria Plan Administration
P.O. Box 800, 105 N. Main, Maryville, MO 64468
Fax: (660) 582-6595

***Note:** Please keep originals for tax purposes. There is no need to forward originals to Citizens Bank & Trust.*

*Questions? Call us at 1-800-399-3023.*

This is page _____ of _____ (include claim form and supporting documentation)

## Flexible Benefits Claim Form

| | |
|---|---|
| **Employer:** | |
| **Employee Name:** | **Social Security Number:** |
| **Address:** | **City, State Zip:** |
| **Work Telephone:**<br><br>**Home Telephone:** | **E-mail Address:** |

### Health Care Reimbursement

| Name (self or dependents) | Expense Description | Date of Service* | Amount of Expense |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| Please attach appropriate receipts and submit with this Claim Form. | | **Total Amount:** | **$** |

*Date of Service is the date the service was performed or the prescription was purchased. It is **NOT** the date you make the payment to the provider. To be reimbursed, a medical claim **MUST** be for a service performed within the Plan Year and while you are an eligible participant in the Plan.

### Dependent Care Reimbursement

| Name of Dependent(s) | Period Covered | | Name, Address, & Taxpayer ID# of Service Provider | Amount Incurred |
|---|---|---|---|---|
| | From | To | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| Please attach a receipt from your daycare provider, or include the daycare provider's signature. | | | **Provider's Signature:** | |
| | | | **Total Amount Incurred:** | **$** |

The dependent care account cannot be overdrafted. Additionally, only expenses incurred to date can be reimbursed.

Do not include amounts paid or eligible for payment under any other health care plan or program, federal, state, or governmental program, worker's compensation, or any other policy of health insurance.

To the best of my knowledge and belief, my statements in this request for reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants. I certify that these expenses have not been previously reimbursed under this or any other benefit plan and will not be claimed as an income tax deduction.

**Employee Signature:** _____ **Date:** _____

**TEAR HERE (Make duplicates of this form as necessary)**