University of Notre Dame
Office of Human Resources

SPENDING ACCOUNT CLAIM FORM

Date ____________________

Name ____ Social Security Number ____________________

Accounting Use Only:
Claim Form Number |__|__|__|__|__|__|

Spending Account claims are processed on approximately the 2nd and 17th of the month, and must be received by the Office of Human Resources at least seven (7) working days prior to the 2nd or the 17th.

Instructions:
Be sure to include your Name and Social Security Number to ensure timely reimbursement.
List expenses in Part B and attach required documentation. You **must** complete the information requested in all the columns except the second column. For example, the "Spending Account Type" column must show "**HC**" (for Health Care) or "**DC**" (for Dependent Day Care). **Expenses must be incurred during the same calendar year in which you made contributions to the spending account.**
•Health Care Expenses:
Attach itemized bills, applicable receipts, Explanation of Benefits (EOB) received from your insurance carrier and other supporting information *(credit card receipts alone are not acceptable)*and *prescription drug labels are needed.*
•Dependent Day Care Expenses:
~Attach either an itemized bill from the day care provider, or a Dependent Day Care Provider's Statement completed by the day care provider. (Dependent Day Care Provider's Statement forms are available on the Office of Human Resources' Web Page.) Day Care receipts **must** show payment has been made.
~Read Part B carefully, then sign and date the form. **Incomplete forms or information may delay the reimbursement process.**
~Send this form with supporting documentation to the Office of Human Resources. **Please retain a copy and photocopies of the supporting documentation for your records.**

PART B: CLAIM INFORMATION (Please Fill Out Completely)

	Spending Account Type HC or DC	HR USE ONLY Claim Type	Date of Service Mo/Day/Yr	Dollar Amount (Not including tax)	Provider (EX: Name of doctor, drug store, day care provider)
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
			TOTAL		***Please use a separate form if you have more than 9 items***

Requests submitted for amounts less than $5.00 will be held until additional claims are received.

PART B: CERTIFICATION
I request reimbursement for the expenses listed in Part A above. I certify that I have not requested reimbursement under this plan or from any other source for the above expenses. I also certify that the total dependent day care expenses for which I am requesting reimbursement do not exceed the lesser of my or my spouse's expected earned income for the year. I further certify that the dependent day care expenses meet all NDFlex Plan requirements. I understand that I cannot claim expenses reimbursed under this plan on my personal income tax return.

Employee's Signature____ Date Signed____________________

Will allow you to print, sign and return to the Office of Human Resources.

Will clear the form.