Flexible Benefit Plan

Claim Form & Filing Instructions

In order to process claims we must have your expenses listed on a claim form and all information needs to be completed on your reimbursement claim form ie., Name, Company, phone or e-mail and at least the last four digits of your Social Security number and be sure to sign and date.

On the reverse side of this page is a claim form. Please feel free to copy this form.

When filing your claim, you must attach copies of the receipts. **The receipt must show the date and type of service for the expense.** Canceled checks, credit card slips, or statements showing only a balance due on your account are not allowable. Please be sure to number each attachment page (i.e., Page 2 of 3, etc.)

If you choose to **mail** your claim with receipts, the address is Claims Processing, Davey Administration Group 3451 W. Shaw Avenue, Suite 101, Fresno, CA 93711. (*Please remember to keep a copy of the claim form and supporting documents for your records.*)

If you choose to **fax** your claim with receipts, the fax number is 559-436-4850.
After you fax a claim and receipts, please ***do not*** follow-up with a hard copy in the mail.
(Remember to keep the original claim form and supporting documents for your records).

To **verify** that your claim has been received, please go to the Web site described below. When your claim is approved, it will appear within three business days on the Web site under "view account". Please ***do not*** call us to confirm that your claim has been received.

You may check your account balance status any time, day or night at the Web site. In addition, the Web site has a claim form, a list of qualifying expenses, and other administrative tools that will help you conveniently manage your account. The site also has frequently asked questions. The Web site address is www.daveyfresno.com, click on the Cafeteria/ "EzFlexPlan".

The EzFlexPlan Web site has everything you Need to manage your Flexible Benefit Account…

- Verify your election
- View your account balance
- Print claim forms
- How and where to file claims
- Look up qualified expenses

Copy the front and back of this claim form for future use

Reimbursement Claim Form

Page ____ of ____

MAIL OR FAX TO:
Claims Processing
DAVEY ADMINISTRATION GROUP
3451 W. Shaw, Suite 101 Fresno, CA 93711
FAX: (559) 436-4850

for account info and more visit:
www.daveyfresno.com

Employer: ______________________________

Name: ______________________________ Social Security: ____________________

Phone: ______________________ E-mail____________________

Dependent Day Care Expense Claims

Name of Dependents	Period Covered		Name, Address and Taxpayer Identification Number of Provider of Service	Amount Incurred
	From	To		
a. attach a receipt from your daycare facility **or** **b.** have the provider sign where indicated			** **Provider's signature**: if no receipt provided	
			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 $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 age 19.

Unreimbursed Medical Expense Claims

Date Expense Incurred	Name of Service Provider	Expense Description OTC Items must have the complete name of the product listed	Person for Whom Expense Incurred	Net Amount
		TOTAL MEDICAL CARE EXPENSE CLAIM		

▶ Attach appropriate receipt(s) and submit this claim form

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