RECURRING CLAIM FORM

EMPLOYER: _____

DATE OF SUBMISSION:_____

Instructions:	**Complete all information and have the form signed by your provider. Complete a new form if rates change or you begin using a different provider.**
	A completed form needs to be submitted for new plan periods.

Employee Name:	
Social Security Number:	Dependent Name: Dependent DOB:
The provider charges a set amount of $ _____ per: ○ Week ○ Bi-weekly ○ Monthly ○ Hour ○ Other _____	
Rates are effective for _____ to _____	
Providers Name (print) Tax ID #	
Providers Address (required or claim will be denied):	

Providers Signature: _____

I certify that I have incurred the expenses for which reimbursement is claimed from the Flexible Spending Account and I further attest that I have not and will not claim credit for these exemptions on my individual income tax returns. I further certify that the above expenses are for the care of qualifying individuals. If an expense for which I am reimbursed is later disallowed by the Internal Revenue Service, I understand that I will be liable for payment of any related income or payroll taxes relating to such improper expense reimbursement. I fully understand that I am responsible for the sufficiency, accuracy and veracity of the information relating to this claim.

Signature_____Date_____
Employer Name _____

Please mail claim form to: Phillips Resource Network Flex Department, P.O. Box 653, Overland Park, KS 66201-0653
913.236.7777 • 913.261.0083 Fax • PRNS125@phillipsresource.com • www.phillipsresource.com