FAX TO: 520-722-7127
or MAIL TO:
Mountain States Administrative Services
7202 E Rosewood, Suite 200
Tucson, AZ 85710
Please do not use a cover sheet when faxing.

FLEXIBLE SPENDING ACCOUNT CLAIM FORM

PLEASE **PRINT** OR **TYPE** ALL ITEMS

NAME OF EMPLOYER **National Optical Astronomy Observatory**				DATE OF CLAIM
NAME OF EMPLOYEE FIRST	MI	LAST		ALTERNATE ID # **N2673 _ _ _ _ _**
ADDRESS: STREET	CITY	STATE	ZIP	DAYTIME TELEPHONE

STATEMENT OF CLAIM

- The undersigned participant in the Flexible Spending Account Plan (FSA 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 a participant in the FSA Plan.
- The undersigned participant certifies that the medical expenses submitted have not been reimbursed or are not reimbursable under any health plan coverage.
- The undersigned fully understands that he or she alone is responsible for the sufficiency, accuracy and veracity of all information relating to this claim.
- The undersigned agrees to provide additional verification of these expenses in the event of an audit by the Internal Revenue Service.
- The undersigned hereby requests reimbursement for the eligible expenses listed below for the Participant or Participant's eligible dependents

SIGNATURE OF EMPLOYEE ______________________________ **DATE** ______________________________

DEPENDENT CARE EXPENSE CLAIMS (Example: Day Care Expenses)

Name of Dependent	Age	Period Covered by Expenses From	To	Name and Address of Provider of Service	SS# or EIN Of Provider	Amount of Claim

ATTACH COPY OF EACH RECEIPT - MARK RECEIPT WITH EMPLOYEE ALTERNATE ID NUMBER
RETAIN ORIGINAL FOR YOUR RECORDS

HEALTH CARE EXPENSE CLAIMS

Person for Whom Expense Incurred and Relationship	Date of Expense	Provider of Service	Expense Description	Amount of Claim

ATTACH COPY OF EACH RECEIPT - MARK RECEIPT WITH EMPLOYEE ALTERNATE ID NUMBER
RETAIN ORIGINAL FOR YOUR RECORDS