MANATT'S INC.

Flexible Spending Account Claim Form

Medical Expense Report

For Office Use Only
Date Received:
Withholdings:

Please be sure all highlighted areas have been completed

Employee Name (Please Print) _____ **SSN:** _____

New Address: _____
Street Address City/State Zip + 4

Check Employer Manatt's: ❑ ; MAS: ❑ ; Wendling: ❑ ; WAMS: ❑ ; Illowa: ❑ ; Ben Tech: ❑
United: ❑ ; Norris: ❑ ; L. L. Pelling: ❑ ; Pelco: ❑ ; Determann: ❑

Date of Service	Patient Responsibility	Expense Type	Provider Name (Pharm, Dr., Hosp)	Patient Name
Total				

Expense Type

MD = Medical Care
CR = Chirporactic
RX = Prescription
DN = Dental Care
VS = Vision/Eye Care
HR = Hearing Care
OV = Over-the Counter Meds
OR = Orthodontic Care

Definitions
Dates of Service – The date the service was incurred, NOT date billed or date paid. Prescription drugs are based on the date the prescription is filled; eye glasses/contact lenses are based on the date ordered.
Incurred – The date you or your eligible dependent is provided the care that gives rise to the medical, dental, vision, prescription, or other qualifying expense.
EOB – This is the Explanation of Benefits that you receive from your insurance provider and should be used for anything that is covered by insurance.

Employee Certification
I certify the expenses for which I am claiming:
- Were incurred by me or my eligible dependents (spouse is considered a dependent) during a plan year in which I and/or my dependent(s) were covered under this Plan.
- If over-the-counter medication or drugs; 1) they were incurred solely to alleviate or treat personal injury or sickness, and 2) the quantity purchased is reasonably able to be consumed during the plan year in which they were purchased.
- Will not be claimed as a deduction or credit on any personal income tax return.
- Are eligible according to the terms of the Plan. If I've received a reimbursement for expenses later found ineligible, I will be responsible for taxes or penalties arising from the ineligible expenses.

I certify that I have not been reimbursed for these expenses from this Plan, nor have they or will they be reimbursed by any other source. I further certify that the information I provide on this form is correct.

Mail Form and Receipts to: Manatt's Inc.; Attn. Roni Reever; P. O. Box 535; Brooklyn, Iowa 52211-0535

PLEASE SIGN: _____ **Date:** _____
(Must be signed by employee)