Consumer Choice Plans

Catholic Diocese of Jackson Dependent Care and FSA Claim Form

A. Employee Information:

1. Name of Employee:
2. The Last five digits of your Social Security Number:
3. Email Address:
4. Address: Street
   City State Zip

B. Reimbursement Guidelines

1. The requested reimbursement must be for an IRS qualified expenseinurrect during the plan year.
2. The requested reimbursement must not have been previously reimbursed nor are you seeking payment insurance or from any other source.
3. You can not claim these expenses as a deduction on your personal income tax return.
4. Attach a copy of your insurance company's Explanation of Benefits or copies of receipts if there is no insurance coverage.
5. If for medical care, the information submitted must contain the name of the provider, the date of service, the dollar amount of the service and the name and number of the prescription drug.
6. If for a day care reimbursement, please includethe singature of the day care provider and the tax ID number.

C. Medical Reimbursement

1. Name of Provider:
   Patient Name:
   Dollar Amount:
2. Name of Provider:
   Patient Name:
   Dollar Amount:
3. Name of Provider:
   Patient Name:
   Dollar Amount:

D. Dependent Care Reimbursement:

1. Total Amount Requested:
2. Dates of Service: From: To:
3. Provider Name:
4. Provider Address:
5. Provider ID#:
6. Provider Signature:

I certify that the attached expenses have not been and will not be reimbursed through my or my dependent's insurance plans.

Signature: _____ Date: _____

Consumer Choice Plans, P. O. Box 2870, Paducah, KY 42002
1-800-811-8194 voice, 1-270-477-0780 fax

Consumer Choice Plans
PO Box 2870
Paducah KY 42002

Direct Payment Authorization

Please complete the form as indicated below and attach a voided check

Authorization for Direct Payment from your bank account

Name:_____ EIN:__ __ __ __ __ __ __ __ __

Bank:_____ City:_____ State:_____

Account Number: _____ Routing Number _____

I hereby authorize and request Consumer Choice Plans, to initiate debit entries to my □Checking / □Savings account at the depository financial institution hereafter called DEPOSITORY as indicated above. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law.

This authorization is to remain in full force and effect until Consumer Choice Plans has received written notification from me of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

_____ _____
Signature Date

Please attach a voided check in the box below: