CLAIM FORM

ROCKY MOUNTAIN reserve
PO Box 631458, Littleton, CO 80163
P: 888-722-1223, FAX: 866-557-0109
claims@rmrbenefits.com
www.RockyMountainReserve.com

Name: _____

Employer: _____

Email Address: _____ **SSN:** _____

Mailing Address: _____

Daytime Phone Number: _____ **Plan Year:** _____

Health Care Expenses

Accounts: FSA = *Flexible Spending Account*, **HRA** = *Health Reimbursement Arrangement*, **PKG** = *Qualified Parking Account*, **TRN** = *Qualified Transit Account,* **WELL** = *Wellness Account*

Date of Service	Account	Type of Service	Patient	Amount
		Total Amount Claimed:		

Dependent Care Expenses

Date of Service From:	Date of Service To:	Dependent Name	Amount
		Total Amount Claimed:	

Dependent Care Provider Information:

Name: _____ **Provider Signature:** _____

(Provider name and signature is only required in the absence of a receipt from the daycare provider)

The undersigned participant in the Plan certifies the following:

- 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 Account with respect to such expenses.
- All expenses were incurred (service provided) in the Plan Year indicated above.
- Both medical expenses and/or dependent care expenses are "qualifying" expenses.
- 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 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.
- Rocky Mountain Reserve is a mere claims paying agent of the employer. All reimbursements are paid out of the general assets of the employer. There is no separate fund or account for the plan. There is no separate fund or account that secures Cafeteria Plan benefits.

A copy of a third party receipt, bill or statement showing an amount and proof of service (not just payment) must be included in order to process this claim.

_____ _____

Employee Signature **Date**