



FRONTEER
PAYROLL SERVICES, INC.

"Freedom For Your Business"

PO Box 1315, 4007 State Street, Bismarck, ND 58502
701-258-9848 Fax 701-258-1011

Benefit Year _____

FLEX BENEFITS CLAIM FORM

Company's Name _____

Employee's Name _____ Social Security # _____

* ALL CLAIM FORMS MUST BE ACCOMPANIED BY RECEIPTS.

DEPENDENT CARE EXPENSE CLAIMS

PERIOD COVERED		NAME OF DEPENDENT	NAME, ADDRESS AND SOCIAL SECURITY NUMBER OF PROVIDER OF SERVICE	AMOUNT INCURRED
FROM	TO			
			(- -)	
			(- -)	
			TOTAL DEPENDENT CARE EXPENSE CLAIMS	

NOTE: The total amount claimed under the Dependent Care Flexible Spending Account for any coverage period must not exceed the lesser of your wages or salary for the Plan Year or the wages or salary of your spouse. (If your spouse is either a full time student or is incapable of taking care of himself or herself then he or she is deemed to have monthly earnings of \$250 if there is one child or dependents, and \$500 if there are two or more.) No payment may be made under the Plan if the service provider is your dependent for federal income tax purposes, or is your child or stepchild and is under age 19.

UNREIMBURSED HEALTH CARE EXPENSE CLAIMS

DATE EXPENSE INCURRED	PERSON FOR WHOM EXPENSE INCURRED	EXPENSE DESCRIPTION	NAME OF SERVICE PROVIDER	NET AMOUNT*
			TOTAL HEALTH CARE EXPENSE CLAIMS	

NOTE: Federal law requires that you submit a written statement (such as an itemized bill from the benefit provider) as well as proof that the claim is not being reimbursed by an Insurance Company. Also, you will not be entitled to claim this expense as a tax deduction.

*NET AMOUNT is the amount of the claim not reimbursed to you through another plan, i.e., insurance.

PLEASE READ CAREFULLY

The undersigned participant in the Health and/or Dependent Care Flexible Spending Account Plan certifies that all expenses for which reimbursement or payment is claimed by submission on this form, were incurred (i.e., services were provided) during a period while the undersigned was covered under the Fronteer Payroll Service Flexible Spending Account Plan with respect to such expenses. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment of 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. The undersigned further understands that no dependent care tax credit or medical expense tax deduction or credit is permitted for amounts for which reimbursement is made.

EMPLOYEE'S SIGNATURE _____

DATE _____

For Plan Administrator use only

Check No. _____

Date _____

Amount _____