Nebraskaland Kansasland
Flexible Spending Account
Claim Form

Submit Claims to:

KLM Business Services
Debbie Leonard, CPA
11750 W. 135th Street #23
Overland Park, KS 66221

Fax Claims to:

913 383-8250

Email Claims to:
dleonard@thillandleonard.com

Name:_____ SSN:_____ Plan Year:_____

Address:_____

Home Telephone: (___)_____ Work Telephone: (___)_____

☐ Change of Address ☐ Need Additional Claim Forms

☐ Please send copies of bills, invoices, and other supporting documents. It is your responsibility to provide support for this claim in the event of audit by the IRS.

☐ The receipt provided must include the name of the provider, date the services were incurred, description of services rendered, person for whom services were provided, and the portion of the bill you are responsible to pay.

☐ You must be certain all medical, dental, and vision expenses have not been reimbursed nor are they reimbursable by any other insurance.

Date Service Incurred	Name of Service Provider	Expense Description	Person for Whom Expense Was Incurred	Net Amount
		TOTAL MEDICAL EXPENSE CLAIM		

The total amount claimed under the plan for any coverage period must not exceed the lesser of your earned income for the plan year or the earned income of your spouse (If your spouse is either a full time student or is incapable of taking care of him/herself then he or she is deemed to have monthly earnings of $200 if there is one (1) child or dependent, and $400 if there are two (2) 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 under the age of 19. **I CERTIFY THAT: 1) the expenses have been incurred, 2) The medical expenses have not been reimbursed nor are they reimbursable by any other health plan coverage, and 3) I will not claim the expenses as a deduction on my personal income tax return. All expenses claimed for reimbursement must be accompanied by a copy of the original bill or other written statement from a third party showing the day and amount of expenses incurred.**

_____ _____

Employee's Signature Date