Health Care or Dependent Care Flexible Spending Account
CLAIM FORM

JOHNS HOPKINS
EMPLOYER HEALTH PROGRAMS

GENERAL

Employee

Last name | First name | Middle initial | Social Security Number

— —

Address | City | State | Zip

Employer's name

☐ Please check if this is a new address

HEALTH CARE

Please attach a copy of your medical plan's explanation of benefits paid (if the expenses were covered under your or your spouse's health care plan) as well as any bills, receipts, or other documentation of your expenses. Prescription receipts must include the name of the prescription. Cancelled checks are not valid receipts. You may attach multiple health care receipts to this claim form.

Total Health Care Expenses **$**

For a complete list of eligible expenses, please see IRS Publication 502, available from the Benefits Office. You will receive an Explanation of Payment with your reimbursement check. Reimbursement checks are processed weekly.

DEPENDENT CARE

Dependent Care Provider

Provider's name | Provider's signature | Social Security or Tax I.D. Number

— —

Address | City | State | Zip

Name of dependent(s) receiving care

1) | 2) | 3)

Date(s) of service | Type of service | **Total Dependent Care Expenses**

$

If you submit a claim for more than you have in your account, you will be reimbursed only for the amount you have in your account at the time. You will be reimbursed for the remaining amount once you contribute additional money to your account. You will receive an Explanation of Payment with your reimbursement check. Reimbursement checks are processed weekly.

Eligible dependent care expenses include day care centers for children or the elderly, day camp, nursery school, day care in a nursing home, and in-home day care. You may not use the Dependent Care Flexible Spending Account for dependent health care expenses.

Mail or fax health care and/or dependent care claims to:

Ceredian Benefit Services
P.O. Box 534055
St. Petersburg, Florida 33747

Fax Number: 1-888-342-5333
Phone Number: 800-992-2437

To the best of my knowledge and belief, my statements in this request for reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year for myself and/or my legal dependent(s). I certify that these expenses have not previously been reimbursed, nor will they be reimbursed under any other benefit plan and will not be claimed as an income tax deduction.

Employee's signature | Date