

HEALTH CARE SPENDING ACCOUNT CLAIM FORM

KECHNIE BENEFITS

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|-----------------------|---------------------|------|--------|-----------------------|
| | | Male | Female | |
| Employee Last Name | Employee First Name | Sex | | Date of Birth (M/D/Y) |
| Employee Address | | | | |
| Employer/Company Name | Employer Address | | | Postal Code |

Your Health Care Spending Account is available to you for submitting expenses that are not eligible under your Group Benefit Plan or for unpaid balances due to co-insurance or deductibles. For any unpaid balance through a spouse's Insurance Carrier please include the Statement of Payment and/or your receipts. Please separate all eligible expenses by claimant and attach receipts:

| Claimant's Name | Relationship To Employee | Date of Birth | Health Expenses | Dental Expenses | Date of Expenses | Amount |
|-----------------|--------------------------|---------------|-----------------|-----------------|------------------|--------|
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- Statement of Payment from Primary/Secondary Insurer included where applicable
- Receipts Attached

Please mail the completed form signed and dated to Kechnie Benefits.

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|---------------------------|---------------------|------|
| | | |
| Name of Authorized Person | Signature of Person | Date |



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