take care®
by WageWorks

HEALTH CARE ACCOUNT
PAY ME BACK CLAIM FORM

TOLL-FREE FAX: 877-782-8889
E-mail: claims@takecareclaims.com
Or mail to take care by WageWorks, PO Box 14054, Lexington, KY 40512

To ensure speedy processing:
DO NOT USE A FAX COVER SHEET

ACCOUNT HOLDER INFORMATION

Last Name

First Name

Social Security Number

Employer / Program Sponsor's Name

Zip Code

Birth Month/Day (MM/DD)

E-mail Address (complete only if new)

CERTIFICATION AND AUTHORIZATION

The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the Company's Flexible Benefit Plan with respect to such expenses and that the 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 relating to this claim which is 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.

Employee's Signature

Date

UNREIMBURSED MEDICAL EXPENSE CLAIMS

Date Expense incurred (mm/dd/yy)	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount
Attach appropriate receipt(s) and submit with this claim form		**Total Health Care Expense Claim**		0.00

To complete an electronic claim form or check your account balance go to takecareWageWorks.com