KLERER FINANCIAL SERVICES, INC.

3272 Merrick Road, Wantagh, New York 11793-4339

Insurance & Investments
Employee Benefit Plans
Financial Planning

Phone: (516) 409-5500
Fax: (516) 409-6100
E-mail: kfs@klerer.com

MEDICAL CARE FLEXIBLE SPENDING ACCOUNT CLAIM FORM

Company: Date of Hire (Mo/Day/Yr)_______________

Address_________________________ Date of Birth (Mo/Day/Yr)_______________

Telephone_______________________ Marital Status: ____Single ____Separated

Employee Name___________________ ____Married ____Divorced ____Widowed

Address_________________________ Social Security #_________________

City______________________ State __________ Zip _____________

List of Expenses

Date Incurred	Service Provided	Amount
________	____________________________	$ ________
________	____________________________	________
________	____________________________	________
________	____________________________	________
________	____________________________	________

Total Expenses: $ ________

Less medical care expenses that I have been paid by insurance or HMO coverage: $ ________

Equals Reimbursable Expenses: $________

Attach documentation (explanation of benefits) from an independent third party stating that the medical expenses have been incurred and the amount of such expense.

Coverage

For you:

Medical ___ Yes___ No Insurance Co__________
HMO ___ Yes___ No Name of HMO________
Dental ___ Yes___ No Insurance Co__________

For your dependents:

Medical ___Yes ___No Insurance Co________
HMO ___ Yes ___No Name of HMO_______
Dental ___ Yes ___No Insurance Co_________

Spouse and Dependent Information

If expenses were for your spouse or dependent:

____________________	____________	______________
Person's Name	Date of Birth	Relationship
____________________	____________	______________
Person's Name	Date of Birth	Relationship

Your dependent is your spouse, child or other person for whom you may take a deduction under Internal Revenue Code Section 152 for medical expenses deductible under Internal Revenue Code Section 213. Expenses incurred for dependents of divorced parents qualify irrespective of which parent claims the children as a dependent.

Signature

I certify that the expenses listed above have been incurred by me and qualify for reimbursements and that these expenses will not be claimed as a deduction on my personal income tax return. In addition, the expenses listed above have not been reimbursed and are not reimbursable under any other health plan. The bills, receipts or other evidence of the expenses are attached.

________________________________ ______________
Your Signature Date

Securities offered through Northeast Securities, Inc. Member NASD - SIPC
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