40 Calhoun Street // Suite 450 // Charleston, SC 29401 // 800.815.3314 // www.tccba.com

Flexible Spending Claim Submittal Form

Employer: _____

Employee Name_____Social Security Number_____

Phone:_____

Dependent Care Expense Claims

Name of Dependent(s)	Period Covered		Name, Address, & Taxpayer ID# of Provider of Service	Amount Incurred
	From	To		
			Total Dependent Care Expense Claim	**$**

NOTE: ***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.***

Unreimbursed Medical Expense Claims

Date Expense Incurred	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount
		Total Medical Care Expense Claim		**$**

Read Carefully: The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the Company's Cafeteria Plan with respect to such expenses and that the medical expenses have not and will not be 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 related to such expense.

_____ _____

Employee's Signature Date

Mail, Email or Fax Claim Form to:
TCC Benefits Administrator
PO Box 22557
Charleston, SC 29413
Fax: (803) 264-4197
Attn: Page Murphy or Rob Degges
pmurphy@tccba.com or rdegges@tccba.com

If claim form is submitted after 4:30pm please call (843) 722-2115 to verify receipt.