Keating & Associates, Inc.

1011 Poyntz Ave, Manhattan, KS 66502

Claim Form

Name:_____ **Last four digits of Social Security #:** _____

Address Change:_____ **Employer:** _____

_____ **E-Mail:** _____

FSA – Medical Claim Information (Please complete)

Date of Service	Person for whom Expense was incurred	Provider - attach copy of receipt**	Amount
1.__/__/__			$_____
2.__/__/__			$_____
3.__/__/__			$_____
4.__/__/__			$_____
5.__/__/__			$_____
		Medical Care Total	$_____

Dependent Care Claim Information

To/From Service dates	Daycare Provider attach receipt/statement	Amount
1.__/__/__ -__/__/__		$_____
2.__/__/__ -__/__/__		$_____
3.__/__/__ -__/__/__		$_____
	Dependent Care Total	$_____

*****Under penalties of perjury, I swear that the amounts indicated above are reimbursable to me, incurred by me during the plan year, paid by me during the plan year, and satisfy the requirements of the employee cafeteria benefit plan of_____.

(Your Company Name)

Date:_____ Employee Signature: _____

SEND COMPLETED FORM AND RECEIPTS TO:

Keating & Associates, Inc.
Cafeteria Department
1011 Poyntz Ave.
Manhattan, KS 66502
537-0366

CONTACT INFO:

claims@keatinginc.com
Fax: 785-537-0747 Local
Fax: 877-537-0747 Toll Free

The qualified receipt must include: **the date of service, the description of service, whom it was for, who provided the services, and the amount of the expense.**