Diversified Administration, Inc.
Tax Savings For Employers & Employees

3 Ways To Submit Your Claim Form and Receipts
E-mail: **Claims@Div125.com**
Fax 954-983-9695 or 954-983-0574
6600 Taft Street Suite 304, Hollywood, FL 33024

Reset the Form | Submit via E-Mail | Secure Upload

Want us to confirm receipt of your claim? Just put your @ or # ______________________

Employer Name ______________________ **Today's Date** ____/____/____

Employee Name ______________________ **Last 4 Digits of your SSN** ________

To view tips which will help ensure the quick and accurate processing of your claim, click here.
To view a short video showing this claim form's many high-tech features, click here.

Please select the correct benefit for your reimbursement.
If you have any questions not addressed in the links above, please contact us at 954-983-9970.

FSA Medical Flexible Spending Account
HRA Health Reimbursement Arrangement
DCAP Dependent Care Assistance Program

Which Benefit Is Being Claimed (FSA / HRA / DCAP)	Dates the Service or Expense Occured	Recipient of Service or Expense	Name of Service and Provider	Reimbursement Total Claimed	Did You Use Your MySource Card
☐ ☐ ☐	From: ___/___/___ To: ___/___/___	○Self ○Spouse ○Child Name:______	______	$	☐ Yes ☐ No
☐ ☐ ☐	From: ___/___/___ To: ___/___/___	○Self ○Spouse ○Child Name:______	______	$	☐ Yes ☐ No
☐ ☐ ☐	From: ___/___/___ To: ___/___/___	○Self ○Spouse ○Child Name:______	______	$	☐ Yes ☐ No
☐ ☐ ☐	From: ___/___/___ To: ___/___/___	○Self ○Spouse ○Child Name:______	______	$	☐ Yes ☐ No
☐ ☐ ☐	From: ___/___/___ To: ___/___/___	○Self ○Spouse ○Child Name:______	______	$	☐ Yes ☐ No
☐ ☐ ☐	From: ___/___/___ To: ___/___/___	○Self ○Spouse ○Child Name:______	______	$	☐ Yes ☐ No
☐ ☐ ☐	From: ___/___/___ To: ___/___/___	○Self ○Spouse ○Child Name:______	______	$	☐ Yes ☐ No
☐ ☐ ☐	From: ___/___/___ To: ___/___/___	○Self ○Spouse ○Child Name:______	______	$	☐ Yes ☐ No
☐ ☐ ☐	From: ___/___/___ To: ___/___/___	○Self ○Spouse ○Child Name:______	______	$	☐ Yes ☐ No
☐ ☐ ☐	From: ___/___/___ To: ___/___/___	○Self ○Spouse ○Child Name:______	______	$	☐ Yes ☐ No
☐ ☐ ☐	From: ___/___/___ To: ___/___/___	○Self ○Spouse ○Child Name:______	______	$	☐ Yes ☐ No

☐ I understand I must provide substantiating documentation along with a completed claim form in order to get the reimbursements totaled below .

FSA TOTAL $ ______ **HRA** TOTAL $ ______ **DCAP** TOTAL $ ______

The undersigned participant in the Plan certifies that all expenses 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 or HRA with respect to such expenses and that the medical expenses have not been reimbursed or will not be reimbursed under any other health insurance 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.

X ______________________
Employee's Signature

Secure Upload | Submit via E-Mail