Please send this form to:
Email: claims@melodybenefits.com
Fax: 781-693-9531

Melody Account Claim Form

Personal Information

First Name:_____ Last Name:_____

Social Security Number: _____--_____--_____ Employer: _____

Phone Number: (_____) _____ E-Mail: _____

If your address has changed please list the new address below

New Address: _____

City: _____ State: _____ Zip code: _____

Claim Information

a) Transit **b) Phone bill** **c) Pharmacy/Prescribed Drug** **d) Dependent Care** **e) Eye/Dental Care**

Person for Whom Expense was Incurred	Date(s) of Service	Name of Service Provider	Description of Services	Amount

***** Credit card receipt are not acceptable*****

Dependent Care Information

Please complete the following information if you are unable to get a receipt form your dependent care provider.

_____

Provider Name *Service Start Date* *Service End Date*

Provider Address: _____ City: _____ State_____ Zip:_____

Provider Tax ID/SSN: _____ Provider Signature: _____

READ CAREFULLY

The above is a true and accurate statement of all expenses incurred by my eligible dependents or me on the date(s) indicated, and I will not seek reimbursement from any other plan including a Health Savings Account (HSA). I understand that I cannot claim any reimbursed expenses on my income tax return, and that I may be liable for payment of all related taxes including Federal, State, or City income tax and any associated penalties on the amounts paid for any expense improperly claimed under the provisions of this plan.

Employee Signature: _____ Date: _____

Access your account information 24 hours a day, seven days a week on our web site: **www.melodybenefits.com**