

Personnel Office  
Township of Ocean School District

**CHANGE OF ADDRESS / NAME/PHONE NUMBER/CODE RED FORM**

This change reflects:

\_\_\_\_\_ Name Change

\_\_\_\_\_ Address Change

\_\_\_\_\_ Phone Number

NAME \_\_\_\_\_

FORMER NAME \_\_\_\_\_

SCHOOL / DEPT. \_\_\_\_\_

NEW ADDRESS/NAME/PHONE NUMBER

AS OF:

\_\_\_\_\_ (Date)

\_\_\_\_\_ (Street)

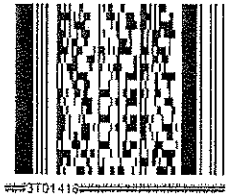
\_\_\_\_\_ (Town or City) (State) (Zip Code)

\_\_\_\_\_ (Home Number and/or Cell Number)

PHONE NUMBER TO BE USED FOR CODE RED:

\_\_\_\_\_

# Request for Reimbursement FSA Claim Form



Employer Name Township of Ocean Board of Education

Employee Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Social Security Number \_\_\_\_\_ Email \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Check here if submitting a Change of Address

Be sure to provide all information requested in each row as outlined in the 1<sup>st</sup> row, which is an example. If the form is incomplete, it will be returned to you. You can send this form along with the third-party documentation substantiating your claim(s) to OCA, 3705 Quakerbridge Road, Suite 216, Mercerville, NJ 08619, or by email at [claims@oca125.com](mailto:claims@oca125.com), or fax directly to 609-514-0111, 609-514-0111 (Alternate), 609-570-8980 (Alternate).

| Date of Service | Is this for a Card Transaction?                          | Patient Name | Relation to Employee | Name of Provider | Description of Service | Amount    |
|-----------------|--|--------------|----------------------|------------------|------------------------|-----------|
| 3/15/19         | <input type="checkbox"/> Yes <input type="checkbox"/> NO | John Smith   | Spouse               | Dr. Jones        | Deductible             | \$ 175.00 |
|                 | <input type="checkbox"/> Yes <input type="checkbox"/> NO |              |                      |                  |                        | \$        |
|                 | <input type="checkbox"/> Yes <input type="checkbox"/> NO |              |                      |                  |                        | \$        |
|                 | <input type="checkbox"/> Yes <input type="checkbox"/> NO |              |                      |                  |                        | \$        |
|                 | <input type="checkbox"/> Yes <input type="checkbox"/> NO |              |                      |                  |                        | \$        |
|                 | <input type="checkbox"/> Yes <input type="checkbox"/> NO |              |                      |                  |                        | \$        |
|                 | <input type="checkbox"/> Yes <input type="checkbox"/> NO |              |                      |                  |                        | \$        |
|                 | <input type="checkbox"/> Yes <input type="checkbox"/> NO |              |                      |                  |                        | \$        |
|                 | <input type="checkbox"/> Yes <input type="checkbox"/> NO |              |                      |                  |                        | \$        |
|                 | <input type="checkbox"/> Yes <input type="checkbox"/> NO |              |                      |                  |                        | \$        |
|                 | <input type="checkbox"/> Yes <input type="checkbox"/> NO |              |                      |                  |                        | \$        |
|                 | <input type="checkbox"/> Yes <input type="checkbox"/> NO |              |                      |                  |                        | \$        |
|                 | <input type="checkbox"/> Yes <input type="checkbox"/> NO |              |                      |                  |                        | \$        |
|                 | <input type="checkbox"/> Yes <input type="checkbox"/> NO |              |                      |                  |                        | \$        |
|                 | <input type="checkbox"/> Yes <input type="checkbox"/> NO |              |                      |                  |                        | \$        |
| Total:          |  |              |                      |                  |                        | \$        |

### Employee's Certification for Disbursement

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

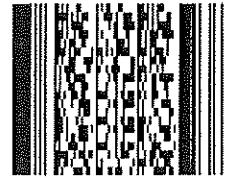
Employee Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm/dd/yy

**Request for reimbursement**  
**DCAP Claim Form**



**Oca**

Office of  
Compliant  
Administration



000003370141600000

Employer Name Township of Ocean Board of Education

Employee Last Name (Please Print) \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security Number \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Employee E-mail Address (if any) \_\_\_\_\_

Be sure to provide all information requested in each row as outlined in the 1<sup>st</sup> row, which is an example. If the form is incomplete, it will be returned to you. You can send this form along with the third-party documentation substantiating your claim(s) to OCA, 3705 Quakerbridge Road, Suite 216, Mercerville, NJ 08619, or by email at [claims@oca125.com](mailto:claims@oca125.com), or fax directly to 609-514-0111, 609-514-2778 (Alternate), 609-570-8980 (Alternate).

**Dependent Care Claims**

| Service Period |          | Dependent Name | Age | Provider Name | Service Description (DCAP) | Provider Tax ID#/SS# | Amount |
|----------------|----------|----------------|-----|---------------|----------------------------|----------------------|--------|
| From           | To       |                |     |               |                            |                      |        |
| 02/01/16       | 02/28/16 | John Smith     | 11  | ABC Day Care  | DCAP                       | 123456789            | \$100  |
|                |          |                |     |               |                            |                      | \$     |
|                |          |                |     |               |                            |                      | \$     |
|                |          |                |     |               |                            |                      | \$     |
|                |          |                |     |               |                            |                      | \$     |
|                |          |                |     |               |                            |                      | \$     |
|                |          |                |     |               |                            |                      | \$     |
|                |          |                |     |               |                            |                      | \$     |
|                |          |                |     |               |                            |                      | \$     |
|                |          |                |     |               |                            |                      | \$     |
| <b>Total</b>   |          |                |     |               |                            |                      | \$     |

**Provider’s Certification (If the provider signature certification is provided, employees are not required to submit supporting documentation):**  
I certify that I am the above mentioned provider or an authorized representative of the above mentioned provider. I further certify that the services specifically described above were provided by the provider for the above named dependent during the service period specifically described above. NOTE: Do not complete this section if you are not the above mentioned provider or the services described above were not provided (or the participant has not completed the section above).

Provider Name \_\_\_\_\_ Provider Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Providers Tax ID: \_\_\_\_\_

**Employee’s Certification:**  
I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependent(s)), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plan. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
mm/dd/yy