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

oca Office of Compliant Administration

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 1st 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, 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	☐ Yes ☐ NO	John Smith	Spouse	Dr. Jones	Deductible	$ 175.00
	☐ Yes ☐ NO					$
	☐ Yes ☐ NO					$
	☐ Yes ☐ NO					$
	☐ Yes ☐ NO					$
	☐ Yes ☐ NO					$
	☐ Yes ☐ NO					$
	☐ Yes ☐ NO					$
	☐ Yes ☐ NO					$
	☐ Yes ☐ NO					$
	☐ Yes ☐ NO					$
	☐ Yes ☐ NO					$
	☐ Yes ☐ 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

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 1st 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, or fax directly to 609-514-0111, 609-514-2778 (Alternate), 609-570-8980 (Alternate).

Dependent Care Claims

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

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