Universal Services
Account Claim Form

Please send this form to:
Universal Services
427 Kings Hwy Ste 1
Brooklyn, NY 11223
Tel. 866-734-5309
FAX: 718-285-3552
services@universal13group.com

Personal Information

Full Name: _____

Employer: _____

Social Security Number: _____

Phone Number: ( ) _____ E-mail: _____

If your address has changed please list the new address below.

New Address: _____

City, State, Zip: _____

Claim Information

Please complete the following information if you are not able to get a receipt from your transit or daycare provider.

Type of Expense: _____ Amount: _____

Type of Expense: _____ Amount: _____

Type of Expense: _____ Amount: _____

Type of Expense: _____ Amount: _____

Type of Expense: _____ Amount: _____

Type of Expense: _____ Amount: _____

Dependent Care of Transit Certification

Please complete the following information if you are not able to get a receipt from your transit or daycare provider.

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

Dependent Care Only: _____

Provider Tax ID# *Provider Signature*

Employee Signature: _____

Date: _____

- By signing this form, I agree to have my account reduced by the amount requested.
- This claim for reimbursement is only for expenses incurred by eligible plan participants during the plan year.
- These expenses have not been reimbursed nor will I seek reimbursement for these expenses from any other source.
- If additional information is required you will receive a denial letter letting you know what additional information is needed.
- Claims incurred during a grace period will be paid out of the prior year first.
- Orthodontia expenses are paid based on the employer's interpretation of the regulations. Please contact you employer to see if advance payments for orthodontia expenses are allowed