REQUEST FOR REIMBURSEMENT FORM

Employer ____

Employee Name ______________________________ Social Security Number ____-____-____

Address ______________________________ Is this an address change? ❑ Yes ❑ No

City ______________________ State ________ Zip ______________

Complete the information below for expenses incurred by you or your dependents for which you are requesting reimbursement. **If this form is not filled out completely, a delay in reimbursement will occur.** You must provide itemized documentation for each expense or an explanation of benefits statement (EOB). An EOB is the statement from your insurance company showing what they have paid.

HEALTH CARE EXPENSES (Medical, Dental, Vision & OTC Medications)

Date Of Expense	Description Of Expense	Who Incurred Expense	Covered By Insurance?	Amount of Expenses
/ /			❑ Yes ❑ No	
/ /			❑ Yes ❑ No	
/ /			❑ Yes ❑ No	
/ /			❑ Yes ❑ No	
/ /			❑ Yes ❑ No	
/ /			❑ Yes ❑ No	
			Total Requested Reimbursement $	

You must indicate above whether or not insurance will cover any of the above expense. If insurance will cover any of the above expense, you must submit the Explanation of Benefits (EOB) from the insurance company. If insurance will not pay any of the above expense, you must submit an itemized statement showing the date and description of the service, provider's name and address, patient's name and dollar amount of the expense. Please note that if your insurance were ever to cover a medical expense that you received reimbursement for through your Reimbursement Plan, this amount would be taxable to you. It would be considered your responsibility to notify your company.

Certification Agreement

I certify that the statement and information on this reimbursement request form are accurate and true, to the best of my knowledge. I also certify that I am claiming reimbursement for only eligible expenses **incurred during the plan year and for expenses incurred by my IRS dependents and me. I certify that these expenses have not been previously reimbursed under this or any other benefit plan, and I am not eligible to receive additional insurance benefits or reimbursements from any other source for such expenses.** I understand that if I receive reimbursement by another benefit plan that the amount of my reimbursement will become taxable and I will notify my employer immediately. I further certify that I am not applying these expenses toward any federal or state income tax deduction or credit.

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Employee Signature Date

Submit your request to: Flex Administrators, 77 Monroe Center NW Suite 1100, Grand Rapids, MI 49503, OR Fax this form and all documentation to 616-454-6090 or 616-454-9862, OR to submit via email with receipts, send to claims@flexadministrators.com

For additional information call: 616-456-7908 or 800-968-3539, or visit our website: www.flexadministrators.com