

FLEXACCOUNT

Claim Form

EMPLOYER NAME

(PLEASE PRINT)

REQUIRED CLAIM CANNOT BE PROCESSED WITHOUT YOUR SIGNATURE

I certify that I am claiming reimbursement only for eligible expenses incurred during the applicable Plan Year for qualifying individuals. These expenses have not been reimbursed by any other source, nor will they be reimbursed by any other source and will not be claimed as an income tax deduction. The attached documentation supports all expenses for which I am claiming reimbursement. I understand "incurred" means the date that the service is performed.

Participant Signature

Date

EMPLOYEE INFORMATION

REQUIRED - MUST COMPLETE ALL SECTIONS

SSN

Last Name

First Name

MI

Home Address

Check if this is a change in address

City

State

Zip Code

Daytime Phone #

FlexAccount CLAIMS FOR OUT-OF-POCKET EXPENSES

1	Patient's Name	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Service Date (MM/DD/YY)
	<input type="checkbox"/> Prescription <input type="checkbox"/> Over-the-Counter <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Copay <input type="checkbox"/> Hospital <input type="checkbox"/> Chiro <input type="checkbox"/> Insurance <input type="checkbox"/> Other		
	Provider Name	Out-of-Pocket Cost	
2	Patient's Name	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Service Date (MM/DD/YY)
	<input type="checkbox"/> Prescription <input type="checkbox"/> Over-the-Counter <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Copay <input type="checkbox"/> Hospital <input type="checkbox"/> Chiro <input type="checkbox"/> Insurance <input type="checkbox"/> Other		
	Provider Name	Out-of-Pocket Cost	
3	Patient's Name	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Service Date (MM/DD/YY)
	<input type="checkbox"/> Prescription <input type="checkbox"/> Over-the-Counter <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Copay <input type="checkbox"/> Hospital <input type="checkbox"/> Chiro <input type="checkbox"/> Insurance <input type="checkbox"/> Other		
	Provider Name	Out-of-Pocket Cost	
4	Patient's Name	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Service Date (MM/DD/YY)
	<input type="checkbox"/> Prescription <input type="checkbox"/> Over-the-Counter <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Copay <input type="checkbox"/> Hospital <input type="checkbox"/> Chiro <input type="checkbox"/> Insurance <input type="checkbox"/> Other		
	Provider Name	Out-of-Pocket Cost	

You must attach appropriate proof of service for each amount above. Acceptable documentation generally includes a receipt from provider detailing dates of service, description and amount paid by Participant. Credit card receipts and balance forward statements are not acceptable forms of documentation.

TOTAL THIS FORM