BeneFlex

Fax: 877-767-8821 **Website: www.flexaccount.com**

FLEXIBLE SPENDING ACCOUNT CLAIM FORM

Part I: Participant Information (Please Print)

Company Name:
Participant ID:
Participant Name (Last/First/MI):
Participant E-mail:

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*You can also add an email address on our website **www.flexaccount.com**

Part II: Medical Reimbursement Request

Please include an itemized bill, itemized receipt or Explanation of Benefits for medical expenses.

IRS regulations mandate that Over-the-Counter (OTC) Medication require a doctor's prescription. Please attach.

	Date of Service Beginning Date to Ending Date	Provider's Name	Primary or Dependent and Relationship	Expense Description	Reimbursement Requested
1					
2					
3					
4					
5					
6					
7					
8					
	Total Reimbursement Requested >>				$

Part III: Dependent Care Reimbursement Request

Please attach either a bill, receipt or letter from the Provider which contains the following: Provider name, Dependent name, Dependent age or date of birth, date type of service(s) provided, date(s) of service and the amount paid.

	Date of Service Beginning Date to Ending Date	Provider's Name	Provider Tax ID #	Dependent's Full Name and relationship	Reimbursement Requested
1					
2					
3					
4					
5					
	Total Reimbursement Requested >>				$

TO EXPEDITE CLAIM PAYMENT, PLEASE COMPLETE AND SIGN YOUR CLAIM FORM or USE OUR ONLINE CLAIM SUBMISSION

Part IV: Employee Certification for Reimbursement

I hereby certify that:

* All expenses for which reimbursement is requested under the Plan were incurred by myself or, my eligible dependents within the Plan Year of my election.
* Expenses have been paid by me and that in the case of qualifying medical expenses, they have not been reimbursed or are not reimbursable under any other medical coverage; and
* I will not use qualifying medical expenses reimbursed through my medical reimbursement account as deductions when filing my Federal Income Tax return.

I understand that:

* I am fully responsible for the sufficiency and accuracy of all information relating to medical claims which are provided by me; and
* I may be liable for payment of all related taxes and penalties including interest and penalties for the late payment by the Employer for the Employer's share of Social Security and unemployment taxes on amounts paid from the Plan which relate to such expense if the expense is not a qualifying expense under the Plan.
* I am responsible for and liable to the Employer and/or BeneFlex, Inc. for any reimbursement I may receive in excess of my contributions to such Plan.
* Reimbursement of Dependent Care expenses will reduce and may eliminate completely my ability to claim a dependent care credit on my personal income tax return;
* Dependent care expenses reimbursed through this account cannot be used as a dependent care credit on my personal tax return; and

I hereby authorize release of payment through my Flexible Spending Account'(s).

Employee Signature: ____ **Date:** ______________________________