REQUEST FOR REIMBURSEMENT FORM

Employer						
EmployerEmployee Name						
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	Sta					
Complete the information If this form is not filled out	below for expenses incurred by you or t completely, a delay in reimbursement ts statement (EOB). An EOB is the sta	your dependents f t will occur. You n	for which you nust provide it	are request temized doo	ting reimburse cumentation f	ement. or each expense
ute to a "health savings acc care (such as annual physic grams) and other expenses	the expense an eligible individual who ount" on his or her behalf)? If the answals and routine well-child care, related incurred after the minimum annual dehealth savings account is only permitted.	wer is "yes," only the tests and immunic eductible under the	hat person's un zations, and to high deducti	ninsured de bacco cessa ble health p	ental and vision ation and obes blan is satisfied	n expenses, preventive ity weight loss pro- I may be reimbursed.
HEALTH CARE EXPER	NSES (Medical, Dental & Vision)					
Date Of Expense	nse Description Of Expense		Who Incurred Expense			Amount of Expenses
/ /						
/ /						
/ /						
/ /						
		7	Cotol Dogues	tad Daimah	ursement \$	
account for the purpose of incurred after the deductib	savings account ("HSA"), I understand claiming reimbursement for uninsure ole under the high deductible health plaiming reimbursement satisfy these reaches the same of the sa	ed dental and visio lan in which I part	n care expens	es and othe	er uninsured h	nealth care expenses
Please submit an itemize amount of charge.	ed receipt from the day care provid	er showing the f	rom/through	n dates of s	service, provi	der's name and
Date of Service (From-To	Child/Dependent's Name	Day Care Provider		Is your de 13 years or		Amount of Expense
				☐ Yes	□ No	
				☐ Yes	□ No	
				☐ Yes	□ No	
				☐ Yes	□ No	
		Т	otal Request	ed Reimbu	ursement \$	
Certification Agreem	ent		_			
I certify that the statement certify that I am claiming a dents and me. I certify that receive additional insuranc by another benefit plan tha	t and information on this reimbursement for only eligible expenses these expenses have not been previouse benefits or reimbursements from an at the amount of my reimbursement was expenses toward any federal or state	ses incurred durin usly reimbursed un ny other source for vill become taxable	ng the plan year nder this or and such expense and I will no	ar and for e ny other be es. I underst tify my emp	xpenses incur nefit plan, and tand that if I i	red by my IRS depen- I I am not eligible to receive reimbursement
Employee Signature			Date			

Submit your request to: Flex Administrators, 3980 Chicago Drive, Suite 230, Grandville, MI 49418, OR Fax this form and all documentation to 616-454-6090. To submit your request 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