Flex Checks

FlexDollars® Reimbursement Request

NOTE: *Do NOT use this form when submitting debit card receipts. To submit debit card receipts simply write you name and Social Security # (or login ID) on the first page of your transmittal. All receipts submitted using this form will be reimbursed if qualified.*

Submit this form to: FlexChecks, Inc. P.O. Box 141215 Grand Rapids, MI 49514-1215 (616) 791-7900
EMAIL: flex@flexchecks.com FAX: (616) 791-7901
This form is located at www.flexchecks.com – Tools & Resources – Forms & Links – Flex Forms
*If submitting claim by US Mail be sure to have correct postage AND staple receipts to this form to insure no processing delays.

Company Name:_____ **Plan Year** (Ex: 2011, or 2010/2011):_____

Name:_____ **SS#:** _____

Address:_____ **City:**_____**State:** _____ **Zip Code:** _____

☐ **PLEASE CHECK IF THIS IS A NEW ADDRESS** **Email Address:**_____

Telephone # between 9am-5pm: _____

This request is for reimbursement of (check one only): ☐ **MEDICAL EXPENSES (Complete Sections A & B)**

☐ **DEPENDENT CARE EXPENSES (Child Care/Day Care) (Complete Sections A, B and C)**

A. LIST OF EXPENSES

If an expense is covered under a medical or dental plan, an "Explanation of Benefits" (EOB) form must be attached. If not covered, attach an itemized statement indicating the date of service.

Date of Service	Provider Name or Type of Service	Amount Requested	FlexChecks Use Only
	Total Reimbursement Requested	$	

B. SPOUSE AND DEPENDENT COVERAGE

If expenses were for your spouse or a dependent:

Name:	Birth date:	Social Security #:	Relationship:
Name:	Birth date:	Social Security #:	Relationship:

C. DEPENDENT CARE INFORMATION (CHILD CARE/DAY CARE)

Please provide Federal Tax I.D. Number or Social Security Number of Dependent Care Provider:

I certify that to the best of my knowledge the expenses listed above have been incurred by me and/or my eligible dependent and will not be reimbursed by any other health benefit plan, nor will I claim this as an income tax deduction or credit on my income tax return. I certify this is an eligible expense, as defined in the Summary Plan Description and the Internal Revenue Code.

If I receive reimbursement for an ineligible expense, I agree to indemnify, hold harmless, and reimburse my employer or its agents for any penalty which may be imposed on any of them resulting from such receipt.

Any person who knowingly files a statement of claim containing any false, incomplete or misleading information with intent to defraud or deceive may be guilty of a criminal act punishable under law.

Employee Signature _____ **Date** _____

PLEASE NOTE: INCOMPLETE CLAIM SUBMISSION MAY RESULT IN A DELAY IN CLAIM PROCESSING AND MAY CAUSE YOUR CLAIM TO BE RETURNED TO YOU. PLEASE BE SURE TO INCLUDE ALL NECESSARY INFORMATION AND BE SURE YOUR CLAIM FORM IS SIGNED AND DATED.