Flex Reimbursement Request Form

Please provide the needed information and attach documentation for each expense.

First Name:	MI:	Last Name:	
Social Security Number or Member ID:		Date of Birth:	
Address:	City:	State:	Zip:
Daytime Phone:	Home Phone:	Email:	

(For notification that form was received)

Unreimbursed Medical/Dental/Pharmacy/Vision Expenses (for you, your spouse, and your dependents)

	Date expense incurred MM/DD/YY	Person for whom expense incurred	Expense Description	Name of Service Provider	Net Amount*
1					
2					
3					
4					
5					
6					
7					
		Total Unreimbursed Medical/Dental/Pharmacy/Vision Expenses $ 0			

Note: If you need additional space, attach a separate sheet of paper.
* NET AMOUNT is the amount of the claim not reimbursed to you through another plan: i.e. health or dental insurance.

Unreimbursed Dependent Care Expenses (Daycare Expenses)

	Period Covered from MM/DD/YY to MM/DD/YY		Name of Dependent	Provider Name, Tax ID, and signature OR a signed receipt from provider is required with each submission	Actual Amount Incurred
1					
2					
3					
				Total Unreimbursed Dependent Care Expenses $ 0	

Note: If same Dependent Care Provider for each claim listed above, signature is required only once.

☐ **Check here if you are not already setup with Direct Deposit for your reimbursements, but would like to be. Attach a voided check for your reimbursements to be directly deposited into your account.**

Read Carefully

The undersigned participant in the plan certifies that all expenses for which reimbursement of payment is claimed by submission of this form, were incurred during a period while the undersigned was covered under the company's cafeteria plan. The undersigned fully understands that he/she alone is responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned and that, unless an expense for which payment of reimbursement is claimed is a proper expense under the plan, the undersigned may be liable for payment of all related federal, state, or city income tax on amounts paid from the plan which relate to such expense.

Employee Signature: Date:

This form may be emailed to **service@healthez.com,** faxed to **952-896-0372,** submitted through your personal online account, or mailed to: **HealthEZ, Claims, 7201 W 78th St Bloomington, MN 55439.** For assistance, call the number on the back of your health plan ID card.