FLEX CLAIM FORM

You must complete, sign, date, and submit a claim form with each batch of receipts submitted.

Employer: ______________________________ Submitted for Plan Year ___/___/___ - ___/___/___

Employee ____SSN _____/_____/_____

Email Address ____

☐ Check here and complete below **ONLY** if this is a new address.

____

Number/Street City State Zip

Non-reimbursed Medical Expenses

Please initial here if the receipts you are submitting with this claim form have not been reimbursed or will not be reimbursed under any other health plan coverage (true out-of-pocket expense) _____________. Your initials here, plus your signature at the bottom of this claim form, will allow us to reimburse your claim without an Explanation of Benefit.

# of Non-reimbursed receipts submitted __________ Total $ amount of receipts submitted $__________

Dependent Daycare Expenses

Attach a copy of your receipt to a completed claim form ***OR*** have the dependent daycare provider complete and sign below (original signature required).

Dependent's name ____ Date of Birth _____/_____/_____

Dependent Daycare Provider __________________________________Tax ID or SSN______________________

Date of Service ____/____/____ through ____/____/____ Amount $______________________________________

____ ____

Dependent Daycare Provider Signature Date

# of Dependent Daycare receipts submitted ______ Total $ amount of receipts submitted $__________

I hereby certify that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while I was covered under the Company's Cafeteria Plan with respect to such expenses and that the medical expenses have not been reimbursed and will not be reimbursed under any other health plan coverage. I further certify that such items will not be deducted or taken as tax credits on my personal federal and state income tax returns for any year. I fully understand that I am responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by me, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, I may be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan which relate to such expense.

____ _______________________________

Employee's Signature Date

Submit claim form with receipts to:

Innovative Employee Benefits, Inc.

PO Box 470257

Charlotte, NC 28247

P 704-341-5981 Toll free: 866-541-5981 F 704-341-5984 Toll free: 866-541-5984