Print Form

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 _____/_____/_____

Phone # _____ Email Address _____

Change of mailing or email address?

_____

Number/Street City State Zip

Non-reimbursed Medical Expenses

(1 of the 3 boxes below must be checked)

☐ **I HAVE A HEALTH SAVINGS ACCOUNT (HSA) AND I AM SUBMITTING DENTAL, VISION, AND PREVENTIVE EXPENSES ONLY FOR REIMBURSMENT. MY HSA ACCOUNT WAS EFFECTIVE ON (MM/YY) _____.**

☐ **I HAVE A HEALTH SAVINGS ACCOUNT (HSA). I'M ATTACHING AN EXPLANATION OF BENEFIT STATEMENT (EOB) FROM BCBS INDICATING I HAVE MET MY DEDUCTIBLE. I AM NOW ELIGIBLE FOR REIMBURSEMENT OF ALL IRS CODE § 213 EXPENSES.**

☐ **I DO NOT HAVE A HEALTH SAVINGS ACCOUNT. I AM ELIGIBLE FOR REIMBURSEMENT OF ALL IRS CODE § 213 EXPENSES.**

# of Non-reimbursed medical receipts submitted _____Reimbursement Requested $_____

(Please keep a copy of your receipts)

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

Phone (704) 341-5981 Fax (704) 341-5984