



77 Brant Avenue, Suite 206, Clark, NJ 07066 Phone: (732) 428-8282
 Email submission to: claims@flexaccount.com or Fax: (732) 428-8111

GRACE PERIOD MEDICAL ACCOUNT REIMBURSEMENT CLAIM FORM...
FOR GRACE PERIOD PARTICIPANTS ONLY!
IF YOUR PLAN DOES NOT INCLUDE A GRACE PERIOD USE A STANDARD CLAIM FORM

IMPORTANT INFORMATION REGARDING THE USE OF THIS FORM

IRS regulations mandate that beginning January 1, 2011 Over-the-Counter (OTC) Medicines/Drugs require a doctor's prescription. Please attach.

- * IF YOUR COMPANY PLAN INCLUDES A GRACE PERIOD USE THIS FORM FOR REIMBURSEMENT.
- * SERVICE DATES AFTER THE GRACE PERIOD HAS EXPIRED WILL BE REIMBURSED WITH FUNDS FROM THE YEAR SERVICE OCCURRED.
- * GRACE PERIOD CLAIMS SUBMITTED FOR REIMBURSEMENT AGAINST THE PRIOR PLAN YEAR THAT ARE IN EXCESS OF THAT YEARS AVAILABLE BALANCE WILL BE CHARGED FIRST AGAINST THE PRIOR YEAR BALANCE AND THEN TO THE CURRENT PLAN YEAR (SO LONG AS YOU ARE PARTICIPATING AND HAVE A SUFFICIENT BALANCE IN THE CURRENT PLAN YEAR).
- * CLAIMS ARE ENTERED 48-72 HOURS AFTER RECEIPT. VISIT WWW.FLEXACCOUNT.COM FOR CLAIM STATUS AND BALANCE INFO.

Part I: Employee Information

Company Name	
Employee Name (Last/First/MI)	Social Security Number
Employee e-mail Address	Daytime Phone Number

Grace Period Claims Must Designate a Plan Year >>>>>>

Plan Year

*** Grace Period Claims with no designation will be reimbursed with funds from the year of service.***

IF ANY OF THE INFORMATION ABOVE NEEDS ALTERATION PLEASE COMPLETE A CHANGE APPLICATION FORM

Part II: Medical Reimbursement Request

	Dates of Service	Provider's Name	Primary or Dependent and Relationship	Expense Description	Reimbursement Requested
	Beginning Date to Ending Date				
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
	Total Reimbursement Requested				\$

TO EXPEDITE CLAIM PAYMENT, PLEASE COMPLETE AND SIGN YOUR CLAIM FORM

Part III: Employee Certification for Reimbursement

- I hereby certify that:
- * All expenses for which reimbursement is requested under the Plan were incurred by myself or, my eligible dependents within the Plan Year of my election.
 - * Expenses have been paid by me and that in the case of qualifying medical expenses, they have not been reimbursed or are not reimbursable under any other medical coverage; and
 - * I will not use qualifying medical expenses reimbursed through my medical reimbursement account as deductions when filing my Federal Income Tax return.

- I understand that:
- * I am fully responsible for the sufficiency and accuracy of all information relating to medical claims which are provided by me; and
 - * I may be liable for payment of all related taxes and penalties including interest and penalties for the late payment by the Employer for the Employer's share of Social Security and unemployment taxes on amounts paid from the Plan which relate to such expense if the expense is not a qualifying expense under the Plan.
 - * I am responsible for and liable to the Employer and/or BeneFlex, Inc. for any reimbursement I may receive in excess of my contributions to such Plan.

I hereby authorize release of payment through my Flexible Spending Account(s).

Employee Signature: _____ Date: _____