BeneFlex

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

HEALTH REIMBURSEMENT ACCOUNT (HRA) CLAIM FORM

Company Name:

Employee Name (Last / First MI)

Employee E-mail Address:

Social Security Number:

VISIT WWW.FLEXACCOUNT.COM FOR CLAIM STATUS AND BALANCE INFORMATION CLAIMS ARE ENTERED 48-72 HOURS AFTER RECIPT

Note: If you have changed your Address please use a BeneFlex Change of Address form. Forms are available at www.flexaccount.com

Part II: Medical Reimbursement Request

	Dates of Service Beginning Date to Ending Date	Provider's Name	Primary or Dependent and Relationship	Expense Description	Reimbursement Requested
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 the service date.
* 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 this 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 t on amounts paid from the Plan which relate to such expense if the expense is not a qualifying expense under the Plan.

I also understand that:

* I am responsible for and liable to the Employer and/or BeneFlex, Inc. for any reimbursement I may receive in excess of my contributions/entitlements to such Plan.

I hereby authorize release of payment based on the rules stated above herein and in accordance with Plan guidelines.

Employee Signature: ____ **Date:** _________________________