



# REIMBURSEMENT REQUEST: Flexible Spending Accounts

## Employee Information

Employer Name \_\_\_\_\_

Employee Name \_\_\_\_\_ SSN \_\_\_\_\_

Phone Number \_\_\_\_\_

## Claim Information

Date of Service	Name of Service Provider	Expense Description	Requested Amount
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
<b>Total Amount Requested:</b>			\$ _____*

\* Please attach to this form all itemized bills, receipts, or any explanation of benefits.

### - Read Carefully Before Signing Below -

I certify that all expenses for which reimbursement of payment is claimed by submission of this form:

- were incurred during a period while I was covered by the flexible spending plan with respect to such expense,
  - have not been or are not reimbursable under any other health plan coverage,
  - are proper under the plan, and
  - that I am fully responsible for the sufficiency and accuracy of all information related to this claim,
- or I may be liable for payment of all related taxes on the amounts paid from the plan relating to such expense.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

**Submit Claims to Flex Advantage:**

Fax to: (877)561-1661

Mail to: 43471 Ridge Park Drive, Suite B, Temecula, Ca 92590

For assistance with all flexible spending claims call toll free (877) 506-1660