



When completed, mail or fax with documentation to:

Flex Corp
820 Gessner, Suite 1225
Houston, Texas 77024
Phone: (866) 401-5272
Fax: (866) 254-2942

IMPORTANT NOTE / INSTRUCTIONS TO PARTICIPANT

For prescription drugs, documentation will include a legible copy of the original drug ticket (not the cash register tape) which includes the date of purchase, the name of the patient, the name of the doctor prescribing the drug, the name of the drug and the name and address of the pharmacy from which the drug was purchased.

For medical, dental and optical expenses, documentation will include an explanation of benefits (from insurance carrier) or legible copy of the itemized statement which includes the following: Name and address of the provider of service, name of patient or whom the service was rendered to, the date the service was provided, a description of the services rendered and the charges for the services.

Employer Name: _____

Employee Name: _____

Social Security #: _____ or Alternate ID #: _____

I have recently used my health care reimbursement plan debit card to pay for medical care expenses. I am submitting this form with the documentation to substantiate that such use of the card was for eligible expenses under the plan. I understand that if any part or all of such use of the card was for ineligible expenses, I will be notified and required to repay to the plan any amounts not eligible. I certify that these expenses have not been paid, nor will I seek reimbursement, from any insurance company under which the service recipient is currently insured.

Employee Signature

Date