



Health Care Request For Reimbursement
(Medical Expenses for Employee and Dependents)



When completed, mail this form and correct documentation to:

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

Employer Name: _____

Employee Name: _____

Social Security #: _____ or Alternate ID #: _____

Address: _____

City: _____ State: _____ Zip: _____

If this is a new address, please indicate by checking the box.

Service Description:

Medical: \$ _____

Dental: \$ _____

Optical: \$ _____

Transportation: \$ _____

(___ miles at .24 cents per mile – 2009 expense)

(___ miles at .165 cents per mile – 2010 expense)

Total Amount: \$ _____

In order to properly qualify, expenses being remitted for reimbursement must be substantiated by an independent third party. This means that someone other than the participant must verify that an expense has been incurred. In order to satisfy this requirement, please furnish a copy of an explanation of benefits (from insurance company) or itemized bills which indicate the name and address of the provider of the service, the name of the person to whom the service was rendered, a description of the service, the date the service was provided, and the amount charged for the service. For prescriptions, please attach the drug ticket. While cancelled checks will serve to verify payment, they will not substantiate an expense being incurred.

Please reimburse the above expenses from my health care reimbursement account in accordance with current guidelines. 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