



HEALTH REIMBURSEMENT ARRANGEMENT (HRA) REQUEST FOR REIMBURSEMENT (MEDICAL EXPENSES FOR EMPLOYEE AND DEPENDENTS)

When completed, mail or fax this form and receipt to:

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

NAME OF EMPLOYER: _____

NAME OF EMPLOYEE: _____

SOCIAL SECURITY # or ALTERNATE ID #: _____

ADDRESS: _____



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

Service Description:

Medical: \$ _____

Dental: \$ _____

Optical: \$ _____

Total Amount: \$ _____

Explanation of Benefits (EOB) attached

Co-pay for office visit, emergency room, prescription, etc

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 copies of explanations of benefits (EOB) from the insurance company which indicate the provider of the service, the date the service was provided, the amount charged for the service, the name of the person to whom the service was rendered and the amount of the patient responsibility. 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 reimbursement arrangement in accordance with current guidelines. I certify that these expenses have not been paid nor are they payable by the insurance contract under which the service recipient is currently insured, or any other source.

Participant Signature _____

Date _____