



Individual Insurance Premium Request
For Reimbursement
(Medical and Dental Insurance Premiums)



When completed, mail or fax this form 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:

Individual Insurance Premiums: \$ _____
(Medical)

Individual Insurance Premiums: \$ _____
(Dental)

TOTAL AMOUNT \$ _____

Copy of policy is attached/has been sent

and I am including one or both of the following:

Monthly statement from carrier(s) attached

Copy of bank draft attached

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 the monthly statement from the carrier or if payment to carrier is made via bank draft, please provide a copy of the monthly draft from your bank statement for the month in which reimbursement is being requested.

Please reimburse the above expenses from my individual insurance premium reimbursement account in accordance with current guidelines. I certify that these expenses have not been reimbursed nor are they reimbursable from any other source.

Employee Signature

Date