



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: \$ \_\_\_\_\_

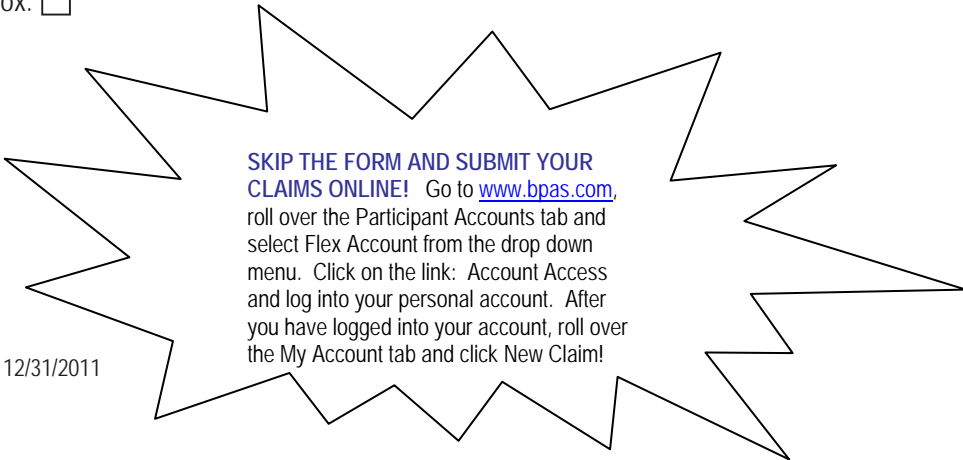
Optical: \$ \_\_\_\_\_

Transportation: \$ \_\_\_\_\_

.235 cents per mile for 2011 expenses incurred between 7/1/2011 and 12/31/2011

.23 cents per mile for 2012 expenses

Total Amount: \$ \_\_\_\_\_



In order to satisfy IRS requirements, the expenses you submit for reimbursement must be substantiated by an independent third party. This means that someone other than yourself must verify that an expense has been incurred. In order to satisfy this requirement, please furnish a copy of an explanation of benefits (from your insurance company) or itemized bills which indicate the name and address of the service provider, 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.

By requesting reimbursement for these expenses and by signing this form, you are certifying that the expenses for which you are seeking reimbursement have not been paid by, and that you will not seek reimbursement for these expenses from, any insurance company or any other employer-sponsored group health plan. You are further certifying that these expenses were incurred by you, your spouse, and/or your dependents in order to provide medical care to you, your spouse, and/or your dependents. For this purpose, your dependent must be someone who qualifies as your tax dependent for federal income tax purposes.

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

\_\_\_\_\_  
Date