FlexibleBenefit ADMINISTRATORS

Ph: 800-437-FLEX or 757-340-4567
509 Viking Drive, Suite F • Virginia Beach, VA 23452
www.flex-admin.com

Limited FSA Medical Reimbursement Claim Form

How to File

Print Form

Form can be submitted by (1) e-mail, (2) fax or (3) mail.

To submit by e-mail, Print Form and sign. E-mail form along with receipts to flexdivision@flex-admin.com

To submit by fax, Print Form and fax to: 757-431-1155

To submit by mail and mail to: Flexible Benefit Administrators, Inc.
P.O.Box. 8188, Virginia Beach, VA 23450

■ Keep a copy of all claim forms and receipts for your records. ■ Notify Flexible Benefit Administrators, Inc. if you have a change in address.
■ Do not mail your claim if you fax it.

Employee Information

Employee's

Print name

Social Security Number or Employee ID #

E-Mail address
(For Notification of Processed Claims, Reimbursement & Account Status)

Employer

Claims For Out-Of-Pocket Expense

Incomplete fields may result in your claim being denied

If you are a participant in the company's HSA you will ONLY be reimbursed for qualifying expenses related to Dental, Vision and Preventive Care.

-Please indicate your qualifying expenses below. DO NOT include expenses reimbursed by any other source.
-Attach copies of bills, receipts, Explanation of Benefits (EOBs) or other claim documentation. Documentation below must include dates of service, description of service and the expense amount. Canceled checks and/or credit card statements/receipts are NOT sufficient proof of your claim.
-Be sure to keep your original receipts, bills, ect. for your records.

	Person treated and Relationship	Type of Eligible Expense	Date of Treatment		Amount of Expense
1				$	0
2				$	0
3				$	0
4				$	0
5				$	0
6				$	0

Note: Orthodontal expenses are reimbursed as designated by the provider. We must have a copy of your orthodontal contract on file.

Total $ 0

As a participant of the Plan, I certify that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while I was covered under my employer's Flexible Spending Plan and that the expenses have not been reimbursed and reimbursement will not be sought from any other source. I fully understand that I am fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, I may be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan which relate to such expense.

Employee's

Signature

Date