FLEXIBLE BENEFIT PLAN
PRIVATE INSURANCE EXPENSES – CLAIM FORM

EMPLOYER____

(Please print above)

Employee's name __________________________________ SS#_________________

PRIVATE INSURANCE EXPENSES____

I hereby file claim for premiums carried individually with a private insurance company and not deducted through my employer or my spouse's employer. I certify that each expense was incurred on the dates and for the persons and reasons noted and has not been reimbursed (and is not reimbursable) under any other plan. **Attached are invoices from my insurance companies and canceled checks, payment receipts or bank statements as evidence of payment of premiums for coverage during the plan year**.

Period of coverage	Person(s) covered	Type of eligible insurance	Amount of premium
________	________	________	$________
________	________	________	$________
________	________	________	$________
________	________	________	$________
________	________	________	$________
________	________	________	$________
________	________	________	$________
________	________	________	$________
		TOTAL	$________

I authorize the service provider to release any information requested by the Plan Administrator in connection with this request for reimbursement.

____ ____________________

EMPLOYEE'S SIGNATURE DATE

Mail This Claim Form To: Flexible Benefit Administrators, Inc. P.O. Box 8188, Virginia Beach, VA, 23450	**Fax Claim Form To:** Flexible Benefit Administrators, Inc. Fax Number: 757-431-1155

Please DO NOT mail your claim form if you fax it. Thank you.

Please notify Flexible Benefit Administrators, Inc. if you have a change in address

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