FLEX CLAIM FORM

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MEDCOM
Your employee benefit solution center

FLEXIBLE BENEFIT PLAN

EMPLOYEE NAME *(Print)* _____

SOCIAL SECURITY NUMBER _____

☐ FORMER NAME, IF CHANGED _____

☐ NEW ADDRESS, IF CHANGED _____
Street

_____
City *State* *Zip*

YOUR CLAIM CAN NOT BE PROCESSED IF THE FOLLOWING SUBSTANTIATION IS NOT ATTACHED

- **Medical Claims**: Insurance Explanation of Benefits (EOB); Medical Provider invoice containing diagnosis; Prescription for treatment, etc.
- **Dependent Day Care Claims**: Invoices itemized by Payment Frequency* and with the name of the Day Care Provider, Tax-ID Number, dates of service and the name of person receiving the service.

Please reimburse me for:

☐ **Medical Expenses Totaling (FSA)** $ _____

☐ **Dependent Day Care Expenses (DCAP) Totaling** $ _____

DCAP CLAIMS WILL NOT BE CONSIDERED FOR PAYMENT UNLESS THE TWO QUESTIONS BELOW ARE ANSWERED

1. *Payment Frequency of DCAP expenses
   ☐ Daily ☐ Monthly
   ☐ Weekly ☐ Other Describe:

2. Did you work all days during the DCAP claim period?
   ☐ Yes (if ***"NO"*** please enter total number business days not worked)
   Total number days not worked: _____ days

EXPENSES INCURRED BY (NAME)	Check ✔ Self	Spouse	Child	DAY CARE Child's Date of Birth	PROVIDER OF SERVICE Include Tax ID if for Day Care	INCURRED DATE	ITEMIZE & TOTAL EXPENSES FSA	DCAP
						TOTAL SUBMITED		

I hereby certify that the above requested reimbursement is for eligible services received by either myself or eligible tax dependents (if any). The above expenses are not payable to me or any eligible tax dependent(s) from any other source, nor will I seek reimbursement under any other plan or source covering health benefits. If the expense(s) is for Day Care, the dependent(s) is an eligible tax dependent. I may not claim the Dependent Care Tax Credit for any reimbursement I receive for this claim.

I further certify that I understand that I must immediately repay ineligible reimbursements. If I have a debit card, it will be deactivated until the full amount of any ineligible expenses is repaid; and, future claims may be off-set; or, at my employer's discretion, ineligible expenses may be payroll deducted from my paycheck. Additionally, because unsubstantiated expenses are considered ineligible expenses by IRS regulations, I understand that I am required to keep and submit receipts to substantiate expenses as requested by the claims administrator. And, I understand that funds I repay the Plan for ineligible expense may be used for reimbursement to me for eligible expenses incurred during the applicable Plan Year.

EMPLOYEE SIGNATURE _____ **DATE** _____