Medical Expense Reimbursement Request

Please complete this form and sign and date as shown below. Attach copies of the Explanation of Benefits from your insurance company or copies of the imprinted, detailed personalized and detailed bills prepared by your care providers. Cash register receipts must show the details of the over-the-counter medications purchased. Detailed pharmacy bills including the name of the prescription medication are required for non-standard co-payment amounts. Keep the copies of your claim and supporting documentation for your records as we cannot provide copies of your claims.

Mail your claim and supporting documents to:

FlexToday, Inc.
PO Box 16099
Fresno, CA 93755

Fax Number:
469-398-0423
Fax Page # _____ of _____

Personal Information – Must Complete Each Claim	***SIGN BELOW – SIGNATURE REQUIRED***
Name of Employer	I, the undersigned, request reimbursement for the expenses submitted herein and certify that these expenses herein have not been reimbursed previously and I will not seek reimbursement under any other insurance or benefit plan for these expenses. I further certify that these expenses were incurred (services received, not necessarily paid) during the coverage period by either myself or my eligible dependents for eligible expenses under the Plan as described in the Summary Plan Description and as defined by all applicable state and federal laws. I assume the responsibility to maintain substantiating documents for all claims submitted for reimbursement. I understand that if my spouse, my dependents or I make or receive contributions to a Health Savings Account (HSA), I must have a Limited Purpose Medical Flex Spending Account and I agree to only submit qualifying expenses related to preventive care, post-deductible, vision and dental care for reimbursement. The Administrator shall have no obligation to any Participant for any act or failure to act, provided the Administrator has acted in good faith in the exercise of its powers in the Plan.
Your Full Name – (First and Last)	
Address	
City, State and Zip Code	
Is this a new address? ☐ Yes ☐ No	**Sign Here** **Date Signed**
Phone Number / **Social Security Number**	***X***_____
Your E-Mail Address	

Total Medical Expenses Claimed With This Request: $_____

Name of Person Receiving Care	Relationship to Employee	Date service provided	Name of the Care Provider	Type of Service	This is my cost for this service
					$
					$
					$
					$
					$
					$
					$
					$
					$