FLEX 125®

Reimbursement Form

Contact Us Today!

www.myflexinfo.com

Date: _____

Fax- # of Pages: _____

Please follow the steps below to thoroughly and accurately complete this form.

Step 1: Personal Information

Company Name: _____

Employee Name: _____ SSN: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____ Email Address: _____

Do you have the mySourceCard™ Debit Card? ☐ Yes* ☐ No *If yes, please indicate below which claims have been paid using the card.

Step 2: Flexible Spending Account Claims

Date of Service (mm/dd/yy)	Name of Provider	Description of Service	Claim Amount	Debit Card
			$	☐
			$	☐
			$	☐
			$	☐
			$	☐
			$	☐

Step 3: Child/Dependent Care Claims

Date Span of Service (mm/dd/yy)	Name of Provider	Provider Tax ID/SS#	Description of Service	Claim Amount
				$
				$
				$
				$
			Total:	$

Reimbursement Schedule- Claim reimbursements are distributed twice a month.

If Flex receives claims by 5 p.m. on the 5th/20th of the month, reimbursement reports will be sent to the employer/employee by the 15th/last day of the month.

Step 4: Acknowledgement and Signature

I acknowledge that my statements in this request for reimbursement form are complete and true. I am claiming reimbursement only for eligible expenses incurred during the application plan year and for eligible plan participants. I certify that these expenses have not been previously reimbursed under this or other benefit plans and will not be claimed as an income tax deduction. I authorize my Flexible Spending Account and/or Child/Dependent Care Account(s) to be reduced by the amount(s) requested.

Employee Signature: _____ Date: _____

Submit a Reimbursement Request in four easy steps…

1. Provide acceptable proof of paid expenses. We request that you send **COPIES** of your proof of expenses since they will not be returned to you. For tax purposes, you should retain the original proof of expense.
   - **Flexible Spending Account** - A copy of the explanation of benefits sent to you by your carrier stating the portion of the claim paid **OR** a copy of the bill from the provider stating the services and date performed and method of payment used.
   - **Child/Dependent Care** - Copies of a 3rd party statement and/or receipt referencing the following information: date span of service, type of service, dollar amount paid, dependent name and the provider's tax ID# or SSN.
2. Write the total amount for reimbursement in the claim amount column.
3. Attach all documentation pertaining to your claim to this form and fax to 847-440-9100.
4. Send request for reimbursement via mail, fax, or email