

# FlexPro™ Claim Form

THIS FORM MUST ACCOMPANY EACH GROUP OF RECEIPTS SUBMITTED

Employer: \_\_\_\_\_

Employee Name: \_\_\_\_\_ Soc. Sec. No.: \_\_\_\_\_  
(Please Print) Last First MI

Home Address: \_\_\_\_\_  
Number/Street City State Zip

Daytime Phone: \_\_\_\_\_  Please check if new address

### The following reimbursement request rules apply:

Healthcare and/or dependent care expenses must be **incurred** within the appropriate Plan Year and prior to reimbursement. Photocopies of receipts are acceptable. Please retain a copy of all receipts for your own records. Cancelled checks are not acceptable receipts. **This form must be signed and accompany each group of receipts submitted.** You may submit receipts by mail or fax.

**Healthcare receipts must** be from an independent third party and **must** include the following information:

- Name of Provider
- Date of Service/Purchase
- Type of Service/Supply Provided
- Charge for Each Service/Supply
- (Names of Prescriptions required)
- Name of Patient

Expenses that may be covered by your (or your spouse's) medical, dental or vision plan **must** first be submitted to the appropriate insurance carrier. The Explanation of Benefits (E.O.B.) you receive from your insurance carrier may then be submitted to *FlexPro™* as a qualifying receipt toward your *FlexPro™* Plan.

Number of Health Care claims attached \_\_\_\_\_

Total dollar amount to be applied to your *FlexPro™* Health Care FSA account \$ \_\_\_\_\_

**Dependent Day Care receipts must** include the following information: Name of Provider, Date of Service, Name of Dependent and Fee for Service OR have your Dependent Day Care provider complete and sign below (original signature required).

Dependent's Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Dependent Day Care Provider \_\_\_\_\_ Tax ID or SSN \_\_\_\_\_

Dates of Service \_\_\_\_/\_\_\_\_/\_\_\_\_ through \_\_\_\_/\_\_\_\_/\_\_\_\_ Total Amount \$ \_\_\_\_\_

Dependent Day Care Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

Number of Dependent Day Care claims attached \_\_\_\_\_

Total dollar amount to be applied to your *FlexPro™* Dependent Day Care FSA account \$ \_\_\_\_\_

To the best of my knowledge and belief, my statement in this Request for Reimbursement is complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants. If this claim includes medical expenses, I certify that these expenses have not been previously reimbursed under this or any other health plan or are not reimbursable under any other health plan coverage. I authorize my Flexible Spending Account(s) be reduced by the amount requested.

- Attention Flex Convenience MasterCard users:**
- None of the attached claims were purchased using the *Flex Convenience* MasterCard
  - Some of the attached claims were purchased using my *Flex Convenience* MasterCard  
(Please write "FlexCard" on claim(s) purchased with your *Flex Convenience* MasterCard)
  - All of the attached claims were purchased using my *Flex Convenience* MasterCard

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_

Please submit this form & receipt(s) **by Mail:** FlexPro / KBA  
P.O. Box 55210, Indianapolis, IN 46205-0210

Or submit via **by Fax:** 866-241-1488

Questions about this form?  
You can reach us toll free  
at 866-867-6883.