HEALTHEZ®

Flex Reimbursement Request Form

Please complete all the information and attach documentation for each expense.

Employer:	Social Security Number:		
First Name:	MI:	Last Name:	
Address:	City:	State:	Zip:
Daytime Phone: ( )	Email:		

(For notification that form was received)

Unreimbursed Medical/Dental Expense (for you, your spouse, and your dependents)

	Date expense incurred *MM/DD/YY*	Person for whom expense incurred	Expense Description	Name of service Provider	Net Amount*
1.					
2.					
3.					
4.					
5.					
6.					
7					
			Total Unreimbursed Medical/Dental Expense Claim $		

Note: If you need additional space, attach a separate sheet of paper.
* NET AMOUNT is the amount of the claim not reimbursed to you through another plan: i.e. health or dental insurance

Unreimbursed Dependent Care Expense (Daycare Expenses)

	Period Covered from **MM/DD/YY** to **MM/DD/YY**		Name of Dependent	Provider Name, Tax ID, and signature OR a signed receipt from provider are required with each submission	Actual Amount Incurred
8.				Provider Signature -	
9.				Provider Signature -	
10.				Provider Signature -	
				Total Unreimbursed Dependent Care Expense Claim $	

Note: If same Dependent Care Provider for each claim listed above, signature is required only once.

☐ **Please check here if you're not already enrolled in Direct Deposit and would like your reimbursement deposited directly into your checking account, and attach a voided check for that account.**

Read Carefully

The undersigned participant in the plan certifies that all expenses for which reimbursement of payment is claimed by submission of this form, were incurred during a period while the undersigned was covered under the company's cafeteria plan. The undersigned fully understands that he/she alone is responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned and that, unless an expense for which payment of reimbursement is claimed is a proper expense under the plan, the undersigned may be liable for payment of all related federal, state, or city income tax on amounts paid from the plan which relate to such expense.

Employee Signature	Date

This form may be submitted online using the "Submit Form" page on your custom benefits website. You may also mail it to: HealthEZ, Claims, 7201 W 78th St Bloomington, MN 55439 **or fax to** 952-896-0372. For assistance, call the number on the back of your health plan ID card.