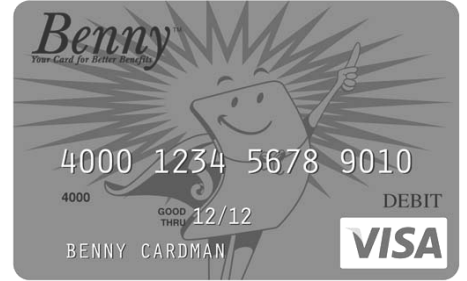




Debit Card Claim Submission
Health Care Reimbursement Plan

When completed, mail or fax with documentation to:

Flex Corp
5700 Northwest Central Drive, Suite 320
Houston, Texas 77092-2092
Phone: 713-939-5858 or 1-800-856-1816
Fax: 713-996-7626 or 713-460-0361



Employer Name: _____

Employee Name: _____

Social Security Number: _____

I have recently used my health care reimbursement plan debit card to pay for medical care expenses. I am submitting this form with the documentation to substantiate that such use of the card was for eligible expenses under the plan. I understand that if any part or all of such use of the card was for ineligible expenses, I will be notified and required to repay to the plan any amounts not eligible.

Employee Signature

Date

IMPORTANT NOTE / INSTRUCTIONS TO PARTICIPANT

For prescription drugs, documentation will include a legible copy of the original drug ticket (not the cash register tape) which includes the date of purchase, the name of the patient, the name of the doctor prescribing the drug, the name of the drug and the name and address of the pharmacy from which the drug was purchased.

For medical, dental and optical expenses, documentation will include a legible copy of the doctor's itemized statement of the charges, including the date of the service, the name of the patient, the name and address of the doctor, a description of the services rendered, the charges for the services and the co-payment amount, if applicable.