



Health Care Request For Reimbursement
(Medical Expenses for Employee and Dependents)

When completed, mail this form and correct documentation to:

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



Employer Name: _____

Employee Name: _____

Social Security Number: _____

Address: _____

City: _____ State: _____ Zip: _____

If this is a new address, please indicate by checking the box. []

Service Description:

Medical: \$ _____

Dental: \$ _____

Optical: \$ _____

Transportation: \$ _____
(___ miles at 24 cents per mile)

Total Amount: \$ _____

- [] Explanation of Benefits (EOB) attached
[] Expenses not submitted to insurance company because expense is not of type covered by insurance policy or because expense will not satisfy the applicable deductible.
[] Co-pay for office visit, emergency room, prescription, etc

In order to properly qualify, expenses being remitted for reimbursement must be substantiated by an independent third party. This means that someone other than the participant must verify that an expense has been incurred. In order to satisfy this requirement, please furnish copies of bills which indicate the provider of the service, a description of the service, the date the service was provided, the amount charged for the service, and the name of the person to whom the service was rendered. For prescriptions, please attach the drug ticket. While cancelled checks will serve to verify payment, they will not substantiate an expense being incurred.

Please reimburse the above expenses from my health care reimbursement account in accordance with current guidelines. I certify that these expenses have not been paid by any insurance contract under which the service recipient is currently insured.

Employee Signature _____

Date _____