

**HEALTH REIMBURSEMENT ARRANGEMENT
 (HRA)
 REQUEST FOR REIMBURSEMENT
 (MEDICAL EXPENSES FOR EMPLOYEE AND DEPENDENTS)**

NAME OF EMPLOYER: _____
 NAME OF EMPLOYEE: _____
 SOCIAL SECURITY NUMBER: _____
 ADDRESS: _____



- If this is a new address, please indicate by checking this box.

SERVICE DESCRIPTION

MEDICAL \$ _____
 DENTAL \$ _____
 OPTICAL \$ _____
 TOTAL AMOUNT \$ _____

- Explanation of Benefits (EOB) from insurance company attached.
- Co-pay for the office visit, emergency room, prescription, ect.

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 explanations of benefits (EOB) from the insurance company which indicate the provider of the service, the date the service was provided, the amount charged for the service, the name of the person to whom the service was rendered and the amount of the patient responsibility. 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 reimbursement arrangement in accordance with current guidelines. I certify that these expenses have not been paid nor are they payable by the insurance contract under which the service recipient is currently insured, or any other source.

 Participant Signature

 Date

Please send claim to:
 FLEX CORP
 5700 NORTHWEST CENTRAL DRIVE, SUITE 320
 HOUSTON, TX 77092
 (713) 939-5858
 (800) 856-1816