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PrimeFlex

Form #4 – Flexible Spending Reimbursement Claim Form – Medical Expenses

PLEASE COMPLETE THIS FORM AND FAX IT – ALONG WITH COPIES OF YOUR RECEIPTS – TO PRIMEFLEX AT 484-323-1593.

To be completed by employee (Please print clearly)

Employee Information

| | | |
|--|-------------------------------|----------------------|
| Name (Last, First, Middle) | Social Security Number - - | Date of Birth / / |
| Address (Street, City, State & Zip Code) | | |
| Employer | Work Telephone Number () | |
| Email | Home Telephone Number () | |

Eligible Medical Expenses To Be Reimbursed

Please only list out-of-pocket, health care expenses that are eligible for this plan (including deductibles and co-payments). Attach copies of receipts (on a separate piece of paper) supporting each expense item listed below.

| Description of Expense | Family Member | Date Incurred | Amount of Claim |
|--------------------------------|---------------|---------------|-----------------|
| | | | |
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| | | | |
| | | | |
| | | | |
| | | | |
| Total amount this claim | | | \$ |

READ CAREFULLY!

The undersigned participant in the plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form, were incurred while the undersigned was covered under the Plan with respect to such expenses. **IRS regards the date incurred as being when the service is rendered, not when you actually pay the bill.** The undersigned participant also certifies that amounts claimed are not eligible for payment under any other health care plan or program, federal, state or governmental program, workers' compensation, or any other policy of health insurance. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and validity of all information relating to this claim which is provided by the undersigned. The undersigned further understands that no medical expense tax deduction is permitted for amounts for which reimbursement is made.

Employee Signature: _____ **Date:** _____ / _____ / _____

Retain the original receipts and a copy of this form for your records. **For Tax Purposes** – Use only for expenses incurred in the same plan year for yourself or members of your family who are dependents.

Mailing address: PrimeFlex Attn: Claims Department 596 Lancaster Avenue Malvern, PA 19355