



Email: [customerservice@flexaccount.com](mailto:customerservice@flexaccount.com)

7 Brant Avenue, Clark, NJ 07066 Tel: (732) 248-8282 Fax: (732) 248-8111

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## Standard Medical & Dependent Care Reimbursement Request Form Instructions

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### Claim Submission:

To expedite your claim payment, forward completed and signed reimbursement claim form, along with appropriate documentation, to the address listed above. Please do not include this instruction page.

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**Fill out the claim form completely and correctly to expedite your claim payment.**

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Your reimbursement can be sent electronically to your banking establishment or mailed to the address of record. If your Company offers electronic transfer (direct deposit), you can sign up by contacting your Human Resource Department.

### Employee Instructions:

Please read these instructions before completing the information requested on the reimbursement claim form.

1. Complete all areas of Part I, "Employee Information".

If you wish to make a permanent change to any of the information in this section please complete a BeneFlex Change Application.

2. Complete Part II and/or Part III, in its entirety and attached bills & receipts for all expenses incurred.

This form is only to be used to request reimbursement for Medical (Part II) and Dependent Care (Part III) expenses.

### Who can file a claim form?

Only employees participating in the Cafeteria Plan can file for reimbursement.

Employees can file a claim form during the plan year and for a certain period after the plan year as described by your plan.

Terminated employees can file a claim form for a certain period after the date of termination if allowed by the Plan.

### What expenses can be claimed?

Only expenses incurred during the plan year can be claimed for reimbursement.

Each year is treated separately and the year of the claim is the year the expense was actually incurred by the participant.

Send separate claim form for each plan year.

### What expenses are eligible?

#### Medical Expenses

Allowable expenses covered, but not fully reimbursed by any other plan.

Allowable expenses not covered by any other plan.

The following supporting documentation must be attached to the reimbursement form:

Explanation of Benefits (EOB). This statement will show the amount of the expense paid by the plan and the amount you must pay AND/OR

Receipts showing type of service/product provided, date of expense, name of person who the service was for, provider name & amount of expense. CANCELLED CHECKS ARE NOT ACCEPTABLE.

#### Dependent Care Expenses

Allowable expenses include care of children or other dependents that are physically or mentally incapable of taking care of themselves.

Children must be under the age of 13.

Services provided by a childcare or elder care center must comply with all state and local laws

Supporting documentation must include:

A copy of paid bill or signed receipt.

Tax Id number for all providers.

3. Read Part IV, "Employee Certification for Reimbursement", then sign and date the form where indicated.

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Questions? Call the BeneFlex, Inc. Customer Service Hotline at 1-888-423-6359 or logon to our website at [www.flexaccount.com](http://www.flexaccount.com)

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PLEASE NOTE OUR NEW ADDRESS, PHONE AND FAX NUMBER

77 Brant Avenue, Suite 206 Clark, NJ 07066 Phone: (732) 428-8282

Fax: (732) 428-8111 Email submission to: customerservice@flexaccount.com

MEDICAL AND DEPENDENT CARE REIMBURSEMENT ACCOUNT CLAIM FORM

Company Name:

Employee Name (Last / First MI)

Employee e-mail Address:

Social Security Number:

VISIT WWW.FLEXACCOUNT.COM FOR CLAIM STATUS AND BALANCE INFORMATION CLAIMS ARE ENTERED 48-72 HOURS AFTER RECEIPT

Note: If you have changed your Address please use a BeneFlex Change of Address form. Forms are available at www.flexaccount.com

Part II: Medical Reimbursement Request

Table with 5 columns: Dates of Service (Beginning Date to Ending Date), Provider's Name, Primary or Dependent and Relationship, Expense Description, Reimbursement Requested. Includes a Total Reimbursement Requested row at the bottom.

Part III: Dependent Care Reimbursement Request

Table with 5 columns: Dates of Service (Beginning Date to Ending Date), Provider's Name, Provider Tax ID #, Dependent's Full Name and relationship, Reimbursement Requested. Includes a Total Reimbursement Requested row at the bottom.

TO EXPEDITE CLAIM PAYMENT, PLEASE COMPLETE AND SIGN YOUR CLAIM FORM

Part IV: Employee Certification for Reimbursement

I hereby certify that: All expenses for which reimbursement is requested under the Plan were incurred by myself or, my eligible dependents within the Plan Year of my election. Expenses have been paid by me and that in the case of qualifying medical expenses, they have not been reimbursed or are not reimbursable under any other medical coverage; and will not use qualifying medical expenses reimbursed through my medical reimbursement account as deductions when filing my Federal Income Tax return.

I understand that: I am fully responsible for the sufficiency and accuracy of all information relating to medical claims which are provided by me; and may be liable for payment of all related taxes and penalties including interest and penalties for the late payment by the Employer for the Employer's share of Social Security and unemployment taxes on amounts paid from the Plan which relate to such expense if the expense is not a qualifying expense under the Plan. I am responsible for and liable to the Employer and/or BeneFlex, Inc. for any reimbursement I may receive in excess of my contributions to such Plan. Reimbursement of Dependent Care expenses will reduce and may eliminate completely my ability to claim a dependent care credit on my personal income tax return; Dependent care expenses reimbursed through this account cannot be used as a dependent care credit on my personal tax return; and

I hereby authorize release of payment through my Flexible Spending Account(s).

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_