FLEX CLAIM FORM

BASIC FLEX

Please type or print all information.

COMPANY NAME: (required for processing)

Social Security Number: (for security purposes please provide at least the last 4 digits of you ss#)

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Employee Last Name:

Employee First Name:

MEDICAL EXPENSES

- Documentation for each request will need to show date of service, description of service provided and charge for service as well as the providers name and address.
- Please itemize your expenses to help assure proper processing. If you have more expenses than this form allows please attach a separate form. If you do not itemize your expenses we will process your claim based on the documentation received
- Mail claims to: 9246 Portage Industrial Dr, Portage MI 49024; Fax: 800-391-6562 or Email to claims@basiconline.com
- For questions please call 800-444-1922 ext 1 or 269-327-1922 ext 1

Date of service	Provider name or name of store	Amount

DAY CARE EXPENSES (dependent care account)

- Please have your day care provider sign this form on the line below or provide a receipt for the services

Signature of day care provider: _____

Dates of service	Day care provider name	Amount

I certify that the statement and information on this reimbursement form are accurate and true. I also certify that I am claiming reimbursement for only eligible expenses incurred during the plan year and only for eligible plan participants. I certify that these expenses have not been or will not be reimbursed under this or any other benefit plan. I further certify I will not claim these, or any other expenses reimbursed through this plan, as an income tax deduction and I assume all liability for taxes and penalties out of any disallowed deduction/credit.

Employee Signature: _____ Date: _____