

## FLEXIBLE BENEFIT PLAN HEALTH CARE EXPENSES – CLAIM FORM

EMPLOYER \_\_\_\_\_  
(Please print above)

Employee's name \_\_\_\_\_ SS# \_\_\_\_\_

### HEALTH CARE EXPENSES

I hereby file claim for the medical expenses noted below. I certify that each expense was incurred on the dates and for the persons and reasons noted. The expense listed below was incurred for medical care not general health purposes and exclude cosmetic and/or toiletries expense(s). I, the participant, certify that I have not been reimbursed for the expense(s) noted below and that I will not seek reimbursement under any other plan covering health benefits. (*mbi* participants: I, the participant, further certify that the expense(s) noted below have not been previously paid for by use of my *mbi* Flex Convenience® stored value card.) **Attached are receipts or bills as evidence of my expenses incurred during the plan year.**

Date of treatment	Person treated and relationship	Type of eligible expense	Amount of expense
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	TOTAL	\$ _____

I authorize the service provider to release any information requested by the Plan Administrator in connection with this request for reimbursement.

EMPLOYEE'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

<b>Mail This Claim Form To:</b> Flexible Benefit Administrators, Inc. P.O. Box 8188, Virginia Beach, VA, 23450	<b>Fax Claim Form To: (Please include cover sheet)</b> Flexible Benefit Administrators, Inc. Fax Number: 757-431-1155
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- Please:**
- Do Not mail your claim form if you fax it.**
  - keep a copy of all claim forms and receipts for your records.**
  - notify Flexible Benefit Administrators, Inc. if you have a change in address.**