flexplan
ADMINISTRATORS, INC

Reimbursement Claim Form

Employer Name _____

Employee Name _____

Social Security Number*_____

Required for reimbursement

Date of Service	*For the Benefit of: (Name & Relationship)*	*Type of Expense (FSA or DCA)*	*Healthcare Expense*	*Daycare Expense (Child/Elder)*
			$	*$*
			$	*$*
			$	*$*
			$	*$*
		TOTAL Reimbursement Requested	*$*	*$*

Certification: I certify the accuracy of the information contained in this claim form and that these claims are for persons covered under this Plan, and that I am not entitled to reimbursement from any other source.

Employee Signature _____ **Date** _____

Instructions:

1. Complete all fields above, sign, date and attach copies of receipts, insurance claim information, etc. to this form.
2. Make a photocopy for your records: include supporting documents with your claim form. Email or fax this form and documents to FlexPlan.
3. Reimbursement funds will be direct deposited to Participants bank account, which will need to be provided. Bank name, account number, routing number and type of account: checking or savings.

Send claim to:

FlexPlan Administrators, Inc.
1135 E. 33rd Place
Tulsa, OK 74105
Attn: Shannon Wilson
Fax: 918-524-6335 Telephone: 918-524-6350
Email: shannon@flexplanadmin.com