flexplan
ADMINISTRATORS, INC

Reimbursement Claim Form

Employer Name _____

Employee Name _____

Email_____ _____

Phone _____

Date of Service	***For the Benefit of: (Name & Relationship)***	***Type of Expense (FSA/HRA/DCA/HSA***	***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 of your records and include supporting documents with your claim form. Email or fax this form and documents to FlexPlan. Supporting documents need to include the service date.
3. Reimbursement funds will be ***direct deposited*** to Participants bank account generally within 3 business days details will need to be provided. Bank name, account number, routing number and type of account: checking or savings. Bank details can also be added online using participant portal. Test deposits will need to be validated.

   Bank Name _____ Routing # _____

   Account Number_____Type of Account _____

Send claim to:

FlexPlan Administrators, Inc.
6314 E. 15th St.
Tulsa, OK 74112
Attn: Jennifer Byrne
Telephone: 918-524-6350
Email: jennifer@flexplanadmin.com (alternate email - flexsupport@flexplanadmin.com)