



FLEXIBLE SPENDING ACCOUNT
HEALTH CARE REIMBURSEMENT PLAN CLAIM FORM

Social Security No. OR Anthem Blue Cross ID No.:

Participant's Name: Last First Middle

HEALTH CARE EXPENSE

Please check the box below that applies. Supporting documentation must accompany this claim form.

- I have group health insurance for this expense. (Please attach the Explanation of Benefits [EOB] statement. The EOB shows how the claim was processed).
I do NOT have coverage for this expense. (Please attach an itemized statement showing the date of service, provider's name, service provided, and paid receipt).
I am submitting expenses for orthodontia. (If you do not have coverage for orthodontia and pay for ongoing treatment, you should submit a paid receipt each time you request reimbursement. If you do have orthodontia coverage, you should submit the Explanation of Benefits [EOB]).
I am submitting over-the-counter drugs for personal use to alleviate or treat personal injuries or sickness. (Please submit a physician's prescription and a receipt that includes the name of the store, date of purchase, the price and the name of the item.)
I am requesting reimbursement for miles. I have included a statement indicating the reason for travel, the date(s) of service and number of miles traveled for reimbursement.

READ CAREFULLY

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the Flexible Spending Account with respect to such expenses and that the health care expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

Employee's Signature

Date

Please send claims to:

FLEX-CARE
Administered By Keenan HealthCare
P.O. Box 2744
Torrance, CA 90509

Phone: (800) 653-3626 x3614
Fax: (310) 212-3381
