2010 FLEX HEALTH-MEDICAL CARE

SECTION 125 – FLEX REIMBURSEMENT CLAIM FORM

HOW TO FILE A CLAIM

1) For out-of-pocket insurance expenses (for example deductibles, co-insurance) copies of the Explanation of Benefits or worksheet from your Health/Dental plan(s).
NOTE: If you or a dependent are covered by two health plans, attach the Explanation of Benefits worksheet from both plans to claim the amount not paid by either plan.

2) For other items considered reimbursable by the IRS, copies of itemized receipts obtained from the provider of the services.

3) **Mail your claim to: Sunwest Employer Services**
3707 N. 7th Street
Suite 300
Phoenix, AZ 85014

Fax: 602-386-3591
Phone: 602-386-3544

ABOUT YOU

Employer's Name _____Sunwest Employer Services, Inc._____

Your Name _____

Your Address _____

_____

Social Security Number_____

HEALTH CARE INFORMATION

Patient: ☐ You ☐ Spouse Name: _____ Date of Birth: _____

☐ Child Name: _____ Date of Birth: _____

☐ Child Name: _____ Date of Birth: _____

Date of Service:	***Provider:***	***Type of Service:***	***Amount:***

PAYMENT AUTHORIZATION

I request payment from my Reimbursement Account for the expenses itemized above and attached. I understand that the expenses reimbursed cannot be claimed on my personal income tax return. I certify that the expenses above have not and will not be paid by any other plan or program of any employer or other person.

Employee Signature _____ Date _____