



## HEALTH REIMBURSEMENT ACCOUNT REQUEST FOR REIMBURSEMENT

### Instructions

1. Complete all sections below. Sign and date.
2. Attach the Explanation of Benefits from your insurance carrier as supporting documentation for your claim.
3. Mail, fax or email the claims to the fax number or address noted below. Email: [claims@yourflex.com](mailto:claims@yourflex.com)

Check if Address  
Has Changed

### Employee Information

Name:	Last 4 digits of SSN: XXX-XX-_____
Street Address:	Employer:
City, State & Zip:	Work Phone #: _____ Home Phone # _____

### Health Reimbursement Account

Insurance Company	Date Policy Covers		Name of Insured	Reimbursable Expense Amount
	From	To		
<b>TOTAL</b>				

### Employee Certification

I request reimbursement from my Health Reimbursement Account(s) for the expenses itemized above. I certify these expenses were incurred for the benefit of myself or another member of my family covered under my health insurance with me. These expenses are not eligible for reimbursement from any other source, and to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plan. I (or we) will not use the expense(s) reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

**Employee Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_