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 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 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 - kholley@flexplanadmin.com)