FLEX CLAIM FORM

BASIC FLEX

Please type or print all information.

COMPANY NAME: (required for processing)

Social Security Number: (for security purposes please provide at least the last 4 digits of you ss#)

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Employee Last Name:

Employee First Name:

MEDICAL EXPENSES

- Documentation for each request will need to show date of service, description of service provided and charge for service as well as the providers name and address. Credit card receipts are not sufficient documentation
- Please itemize your expenses to help assure proper processing. If you have more expenses than this form allows please attach a separate form. If you do not itemize your expenses we will process your claim based on the documentation received
- Secure Claim Upload: https://claims.basiconline.com; Fax: 800-391-6562 or 269-327-0716; Mail claims to: 9246 Portage Industrial Dr, Portage MI 49024
- For questions please call 800-444-1922 ext 1 or 269-327-1922 ext 1

Date of service	Provider name or name of store	Amount

DAY CARE EXPENSES (dependent care account)

- Please have your day care provider sign this form on the line below or provide a receipt for the services

Signature of day care provider: _____

Dates of service	Day care provider name	Amount

I certify that the statement and information on this reimbursement form are accurate and true. I also certify that I am claiming reimbursement for only eligible expenses incurred during the plan year and only for eligible plan participants. I certify that these expenses have not been or will not be reimbursed under this or any other benefit plan. I further certify I will not claim these, or any other expenses reimbursed through this plan, as an income tax deduction and I assume all liability for taxes and penalties out of any disallowed deduction/credit.

Employee Signature: _____ Date: _____