

Individual Premium Account Claim Form

Mail or Fax Claim To: **Benefit Extras, Inc.**
 P.O. Box 1815
 Burnsville, MN 55337
Phone: (952) 435-6858 **Toll-free phone: (866) 435-6858**
Fax: (952) 435-8435 **Toll-free fax: (800) 886-8793**
Email: flex@benefiextras.com

1. Employer/Employee Information

Employer	
Employee Name	
<i>Complete address below <u>ONLY</u> if it has changed</i>	
Address Line 1	
Address Line 2	
City, State and Zip Code	

2. Instructions for Completion

- Complete Sections 1 and 3 of the claim form, sign and date Section 4, attach the required substantiation and submit to the claims administrator.
- Substantiation must include the insurance company name, period of coverage, type of coverage provided and cost.
- Note:** Canceled checks, copies of checks, credit card statements and credit card are not eligible substantiation.
- Claims will be processed upon receipt, compliant with the sufficient balance requirement for Individual Premium Accounts.
- Please refer to the Summary Plan Description available from your Employer for complete details of the Plan.

3. List of Expenses

<u>Individual Premiums:</u>		
*Date Expense Incurred	Description of Expenses	Amount
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Total \$		_____

4. Employee Certification

I, the undersigned, certify that the above expenses were incurred by me (and/or my spouse/or eligible dependents), have been paid by me (or them), were not reimbursed by any other plan, and to the best of my knowledge and belief are eligible for reimbursement under my account. I have attached WRITTEN PROOF (receipts) of these expenses and I (or we) will not use the expenses reimbursed through this account as deductions or credits when filing my (our) individual income tax return. If audited, I understand that it is my responsibility (not my employer's) to provide written proof that these expenses were actually incurred and eligible for reimbursement. In the event that any reimbursement that I may claim and receive under this plan is later determined by the IRS to be unsubstantiated, I hereby acknowledge and accept responsibility for any adverse tax consequences that may result to me. I understand the employer does not accept responsibility for direct payment to any individuals other than the employee.

X _____
Employee Signature (Required)
Date

PLEASE RETAIN A COPY FOR YOUR RECORDS!