Mail or Fax Claim To:	Benefit Extras, Inc. P.O. Box 1815 Burnsville, MN 55337 Phone: (952) 435-6858	ORTHODONTICS ONLY Flex Spending Claim Form Fax: (952) 435-8435

1. Employer/Employee Information

Employer		
Employee Name		

Complete address below ONLY if it has changed

Street		
City	State	Zip
Soc. Sec. #	Date of Birth	

2. Instructions for Completion

- Section 125 of the IRC states participants cannot be reimbursed in advance of the date of service. However by submitting this form, you will eliminate the need to submit paper claims with each recurring monthly **ORTHODONTIC** visit. Benefit Extras will automatically send you a reimbursement check the first day of each month.
- Complete applicable portions of Section 1 of the **Orthodontic Claim Form**.
- Have your dental/orthodontic office complete and sign Section 3.
- **Sign the Employee Certification in Section 4.**
- Fax or mail completed **Orthodontic Claim Form** to Benefit Extras.

3. Orthodontic Expenses (to be completed by the Orthodontic Provider)

Patient Name: ____

Relationship to Employee: ___________________________

Treatment Start Date: _________________________________

Total Treatment Fee: _________________________________

Down Payment Amount & Date: _________________________

Treatment Time in Months: ___________________________

Monthly Charge: ____________________________________

Insurance Coverage Amount: __________________________

Orthodontic Provider: _________________________________

I certify that our office will provide orthodontic care as described above and further certify that this orthodontic services are for treatment and not strictly for cosmetic purposes.

_________________________________ ___________________

Orthodontic Provider Signature **Date**

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 (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!