SECTION 125 FLEXIBLE BENEFIT PLAN
MEDICAL REIMBURSEMENT CLAIM FORM

Please indicate below the type of claim you are submitting.

- ❑ Flex Claim
- ❑ Limited FSA Claim (Dental & Vision only when combined with an HSA account)

Employer Name:	Today's Date:
Employee Name:	Member ID or Social Security Number:
Residence Address:	City / State / Zip Code
E-Mail Address:	Daytime Phone Number:

Instructions:

Please list the amount(s) of reimbursement you are requesting below. Attach copies of receipts for expenses that are eligible for reimbursement. All receipts must contain the provider's name, amount paid, incurred date, and description of service before we can reimburse the claim. (Please Note: Cancelled checks are NOT acceptable receipts.)

Federal law requires that you submit a written statement (such as an itemized bill from the service provider) as well as proof that the claim is not being reimbursed by an insurance company.

Please retain all original receipts
(should you be auditted by the IRS they can request records of up to seven years)

Date of Expense	Description of Expense	Amount Paid
Total Number of Receipts:		Total Amount Requested: $

*If you need more space, please attach additional information.

I certify that the above information is correct and hereby authorize release of payment through my reimbursement account(s). I further certify that these expenses have not been and will not be reimbursed under the Plan, any other health plan coverage, or any other plan. I understand that I am fully responsible for the accuracy and sufficiency of all information relating to this claim. I understand that no medical expense tax deduction credit is permitted on my Federal income tax return for amounts reimbursed under this Plan. The Plan Administrator does not accept responsibility for direct payment to any individual other than the employee.

Employee Signature Date

PLEASE RETURN TO:
Caprock HealthPlans
PO Box 780548, San Antonio, TX 78278
Fax: (210) 348-7112
Section125_Claims@caprockhp.com

PLEASE RETURN FORM TO:
Verity National Group
P.O. Box 780159 . San Antonio, TX 78278
Phone (210) 348-7300 . (800) 840-3977 . Fax (210) 348-7112
Email: Section125_Claims@veritynational.com

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