Non-Employer Sponsored Premium Claim Form

Non-Employer Sponsored Premium Claim

Please submit a detailed billing statement from your insurance carrier. Paid receipts are not sufficient documentation.

Date(s) of Coverage	Insurance Provider	Type of Insurance	Participant Name	Relationship to You	Amount Requested
					$
					$
					$
					$
					$
					$
				Total	$

I certify that all expenses for which reimbursement or payment is claimed by submission of this form were incurred by me, an eligible spouse, or an eligible dependent during a period while I was covered under my employer's FSA Plan and that the expenses have not been reimbursed and reimbursement will not be sought from any other source. I understand that I am fully responsible for the accuracy of all information relating to this claim, and that unless an expense for which reimbursement is claimed is a proper expense under the Plan, I may be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan which relate to such expense. A claim will only be processed with a completed and signed claim form and correct documentation.

Employee Signature _____ **Date** _____

Fax to: 1.866.686.FLEX (3539)
Page 1 of _____
No Cover Page Required

Mail to: Flex Made Easy
4551 W. 107th St., Suite 310
Overland Park, KS 66207

File Online: www.FlexMadeEasy.com
NO CLAIM FORM NEEDED!