Claim Form

1) Please use this document as the email/ fax cover sheet and do not use any other fax cover sheet.
2) Copies of receipts are required to verify your reimbursement requests and must be faxed together with this claim form as a single fax.
3) Please PRINT (or Type)when filling out this form, keep your original receipts and a copy of this claim form for your records.
4) Attached receipts must include thedateof service, the type of service/product provided and the amount (credit card receipts are not valid).

13582

Please complete this Claim Form without modification

SSNumber ☐☐☐ - ☐☐ - ☐☐☐☐

For optimum accuracy, avoid contact with box edges as in this example: 1 2 3 4 5 6 7 8 9 0

Participant Last Name | First Name | M I | Day Phone | Employer

E-mail Address

MedFSA Medical Spending Account; Day care - Dependent Care Spending Account; HRA Health Reimbursement Account;
OIP - Outside Insurance Premium Account, QPK - Qualified Parking Expense; QTR - Qualified Transit Expense

	Date of Service	Claim Type (see above legend)	Describe Service or if Day Care include signature of Provider	Choose only one (Who service was for)	Amount to be Reimbursed
1	☐☐ / ☐☐ / ☐☐	○ Med FSA ○ Day care ○ HRA ○ OIP ○ QPK ○ QTR		○ Self ○ Eligible Adult Dependent ○ Spouse ○ Child (age) (_____)	☐☐☐☐.☐☐
2	☐☐ / ☐☐ / ☐☐	○ Med FSA ○ Day care ○ HRA ○ OIP ○ QPK ○ QTR		○ Self ○ Eligible Adult Dependent ○ Spouse ○ Child (age) (_____)	☐☐☐☐.☐☐
3	☐☐ / ☐☐ / ☐☐	○ Med FSA ○ Day care ○ HRA ○ OIP ○ QPK ○ QTR		○ Self ○ Eligible Adult Dependent ○ Spouse ○ Child (age) (_____)	☐☐☐☐.☐☐
4	☐☐ / ☐☐ / ☐☐	○ Med FSA ○ Day care ○ HRA ○ OIP ○ QPK ○ QTR		○ Self ○ Eligible Adult Dependent ○ Spouse ○ Child (age) (_____)	☐☐☐☐.☐☐
5	☐☐ / ☐☐ / ☐☐	○ Med FSA ○ Day care ○ HRA ○ OIP ○ QPK ○ QTR		○ Self ○ Eligible Adult Dependent ○ Spouse ○ Child (age) (_____)	☐☐☐☐.☐☐

I certify the above expenses were incurred during the Plan Year of coverage by me or my eligible dependents and have not been previously reimbursed by this Plan or any other source, nor are the expenses reimbursable by any other source. To the best of my knowledge, I affirm the above claims are eligible and proper expenses arising under the Plan. I understand that I will be liable for all applicable taxes and penalties for claims which are not eligible and proper expenses under the Plan. By including my email address above, I consent to 24HourFlex communicating with me via email. By typing your name in the box below you are signing this form electronically. You agree your electronic signature is the legal equivalent of your manual signature and that no third party verification is necessary to validate your E-signature..

Participant Signature _____ Date _____

Email to claims to claims@24hourflex.com
Fax claims to (303) 369-0003 or 1-800-837-4817

or Mail to

24hourflex ATTN: Claims
7100 E Belleview Ave Ste 300
Greenwood Village, CO 80111

For more than 5 line items, please log into your account @ www.24hourflex.com, and click on request payment.

Click here to clear all values and start over

Click here if you are ready to print