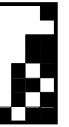




Claim Form

- 1) Please use this document as the 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** when filling out this form, keep your original receipts and a copy of this claim form for your records.
- 4) Attached receipts must include the date of service, the type of service/product provided and the amount (credit card receipts are not valid).

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Please sign and date in the space provided at the bottom of the form

SSNNumber - -

For optimum accuracy, avoid contact with box edges as in this example:

1	2	3	4	5	6	7	8	9	0
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Participant Last Name First Name MI 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 <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	<input type="radio"/> Med FSA <input type="radio"/> Day care <input type="radio"/> HRA <input type="radio"/> OIP <input type="radio"/> QPK <input type="radio"/> QTR		<input type="radio"/> Self <input type="radio"/> Eligible Adult Dependent <input type="radio"/> Spouse <input type="radio"/> Child (age) (_____)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>
2 <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	<input type="radio"/> Med FSA <input type="radio"/> Day care <input type="radio"/> HRA <input type="radio"/> OIP <input type="radio"/> QPK <input type="radio"/> QTR		<input type="radio"/> Self <input type="radio"/> Eligible Adult Dependent <input type="radio"/> Spouse <input type="radio"/> Child (age) (_____)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>
3 <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	<input type="radio"/> Med FSA <input type="radio"/> Day care <input type="radio"/> HRA <input type="radio"/> OIP <input type="radio"/> QPK <input type="radio"/> QTR		<input type="radio"/> Self <input type="radio"/> Eligible Adult Dependent <input type="radio"/> Spouse <input type="radio"/> Child (age) (_____)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>
4 <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	<input type="radio"/> Med FSA <input type="radio"/> Day care <input type="radio"/> HRA <input type="radio"/> OIP <input type="radio"/> QPK <input type="radio"/> QTR		<input type="radio"/> Self <input type="radio"/> Eligible Adult Dependent <input type="radio"/> Spouse <input type="radio"/> Child (age) (_____)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>
5 <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	<input type="radio"/> Med FSA <input type="radio"/> Day care <input type="radio"/> HRA <input type="radio"/> OIP <input type="radio"/> QPK <input type="radio"/> QTR		<input type="radio"/> Self <input type="radio"/> Eligible Adult Dependent <input type="radio"/> Spouse <input type="radio"/> Child (age) (_____)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>

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. I understand that I cannot claim as deductions on my personal income tax Form 1040 expenses for which I have been reimbursed. By including my e-mail address above, I consent to 24hourflex communicating with me via e-mail about all matters pertaining to this claim form.

Participant Signature _____

Date _____

Scan and email to claims@24hourflex.com
 Fax to 303-369-0003 or 1-800-837-4817

or Mail to

24HourFlex ATT: Claims
 2851 S. Parker Road, Suite 230
 Aurora, CO 80014

To insure legibility (eliminating processing delays) you may go to www.24hourflex.com, fill out this form on-line and then print it, sign it and send it in as your claim form.