isolved Benefit Services

FLEX PLAN REIMBURSEMENT FORM

This form is for requesting a reimbursement.

If you are submitting documentation from a debit card transaction, please utilize the documentation submission form.

1454 30th St., Suite 105, West Des Moines, IA 50266 | Ph. 515-224-9400 or 800-300-9691 | Fax 515-224-9256 | www.isolvedbenefitservices.com/kabel

Company Name (Employer) _____ Date _____

Employee Name _____ Social Security Number _____ Phone Number _____

EMPLOYEE MUST SIGN FORM BELOW BEFORE ANY PAYMENT WILL BE ISSUED

Dependent Care Expense Claims (*Attach a receipt from your provider)*

Name of Dependent	Period Covered To	From	Name Address &Tax Payer ID of Provider	Amount

Total

Provider Signature

NOTE: The total amount claimed under the Plan for any coverage period must not exceed the lesser of your earned income for the Plan Year or the earned income of your spouse. (If your spouse is either a full-time student or is incapable of taking care of himself or herself, then he or she is deemed to have monthly earnings of $200 if there is one (1) child or dependent, or $400 if there are two (2) or more.) No payment may be made under the Plan if the service provider is your dependent for federal income tax purpose or is your child or stepchild and is under age 19.

Unreimbursed Medical Expense Claims *(Attach appropriate receipt(s) and submit with claim form)*

Date of Expense	Name of Service Provider	Description of Expense	Person for Whom Expense Incurred	Amount

Total

Individual Insurance Premiums *(Attach appropriate receipt(s) and submit with claim form)*

Name of Insurance	Provider Insured Name	Type of Insurance	Date(s) of Coverage	Amount

Total

Read Carefully: I authorize the above expenses to be reimbursed from my Health FSA Account. To the best of my knowledge, my statements on the Form are true and complete. I certify all of the following: Either I, my Spouse or my Dependent has received the services described above on the dates indicated, and the expenses qualify as valid Medical Care Expenses under Code 213 (d), as further defined in the Health FSA Plan document (the"Plan"). These Expenses have not previously been submitted for reimbursement under the Plan. They have not been reimbursed under this Plan or any other Plan, and I will not seek reimbursement for them under the major medical plan or any other health plan. These expenses are for medical care excluding cosmetic purposes, are not incurred for general health purposes and do not constitute toiletries. I understand that the expenses reimbursed may not be used to claim any federal income tax deduction or credit. I also understand that I may be asked to provide further details about some expenses (e.g., a statement from a medical practitioner that the expense is to treat a specific medical condition or a more detailed certification from me).

Signature _____ Date _____