the Taben Group
Flex Administration in cooperation with Surency life and health

TabenFlex
FSA/HRA CLAIM FORM

Last Name, First Name, MI (Please Print) _____

Employer _____

Social Security Number or Employee ID (EID) as appropriate _____

☐ Check if NEW ADDRESS

Street Address _____

City, State, Zip _____

Requesting Reimbursement from? ☐ Medical FSA ☐ HRA ☐ Dependent Care FSA

Dependent Care FSA

Dependent care expenses must be for a dependent that is incapable of self care or under the age of 13 at the time the care was provided.

Dependent Name	Age	Dates Care Provided		Name and Address of Care Provider	Provider ID/SSN	Amount Requested
		From	To			
					TOTAL	$0.00

I provided the dependent care as stated above:

_____ Care Provider's Signature

_____ Date

Medical FSA or HRA

Plan Type	Date Medical Care Provided	Merchant/Provider Name	General Medical Expense/Item Description	Name of Person Receiving Service/Product	Medical Mileage	Claim Amount (Amount of your responsibility)
				TOTAL	0	$0.00

Attach copies of Explanation of Benefit (EOB) statement(s) or provider receipts if there is no insurance. Copies must include the date(s) of service. Please do not send originals of your EOB's or your insurance statements - keep originals for your records. A signed Letter of Medical Necessity from your provider may also be required if the expense is considered "dual purpose." Dual purpose is defined as those items that have both a medical purpose and a person/cosmetic or general health purpose. **Missing information may delay the processing of your reimbursement.**

Reimbursement Guidelines

1. The reimbursement request expense must be an IRS eligible expense and incurred during the flex plan year. (Claims for future dates of service are not eligible for reimbursement)
2. The reimbursement request must not have been previously reimbursed nor are you seeking reimbursement from insurance or any other source.
3. Attach a copy of your insurance company's Explanation of Benefits (indicating date of service), or copies of receipts/bills if there is no insurance coverage to document the amounts.
4. The medical mileage indicated must be for transportation primarily for and essential to medical care and are associated with the dates of service indentified above. The standard medical mileage rate is set by the IRS annually and will be calculated by The Taben Group when determined eligible expenses for unreimbursed medical expenses.
5. Information provided must include the following:
   - Name of Provider
   - Type of service/supply
   - RX # and name of drug
   - Date of service/purchase
   - Dollar amount of service/supply
   - Signature of day care provider
   - Day care provider tax ID # or SSN
6. Generally, reimbursement requests will not be considered for reimbursement later than 90 days from the end of your company's flex plan year. For specific guidance, please contact your Employer.

I hereby certify that the reimbursement requests I'm submitting are IRS eligible expenses and that I have not been previously reimbursed for these expenses nor am I seeking reimbursement for these expenses from insurance or any other source. I also understand that the Taben Group, its agents or employees, will not be held liable if I submit non-IRS eligible expenses for reimbursement. I understand that the expense for which I am reimbursed may not be used to claim any federal income tax deduction or credit.

(Request cannot be accepted without participant's signature)

_____ Employee's Signature

_____ Date

Submit Form to The Taben Group
ALONG WITH SUPPORTING DOCUMENTATION
Fax 316-462-3392 *No Cover Page Required*
Page 1 of ___
Online claims submission @ flexsupport@taben.com