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

TabenFlex
PREMIUM REIMBURSEMENT REQUEST 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 _____

PREMIUM REIMBURSEMENT ACCOUNT

Insurance Provider/Carrier Name	Coverage Period	Premium Reimbursement Amount Requested
	TOTAL	$ 0.00

Attach copies of your Insurance Provider/Carrier statement(s) or receipts. Copies must include the date(s) of coverage. Please do not send originals of your insurance statements - keep originals for your records.

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 plan year. (Claims for future dates of coverage are not eligible for reimbursement).
2. The reimbursement request must not have been previously reimbursed nor are you seeking reimbursement from any other source(s).
3. The only expenses eligible for reimbursement under this plan are non-employer sponsored health insurance premiums for you and your eligible dependents. **Please check with your employer as to the availability of dependent coverage.**
4. Attach a copy of your insurance company's statement(s) for the coverage period.
5. Information provided must include the following:
   - Name of Insurance Provider(s)/Carrier(s)
   - Address of Insurance Provider/Carrier
   - Date(s) of Coverage
   - Premium Amount
   - Plan Description

   Note: Cancelled checks, credit card receipts or statements that only show "Balance Due" are not acceptable forms of substantiation.
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 to the best of my knowledge, the expenses list above are accurate and complete. I have not been previously reimbursed for these expenses under this plan, any other plan, nor am I seeking reimbursement for these expenses from any other source. I also understand that 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 and that they were incurred for me or my eligible dependents.

(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