



PLAN NAME DEFINITIONS

PLEASE REFER TO YOUR ENROLLMENT LETTER TO VERIFY WHICH PLAN(S) APPLY TO YOU AND YOUR EMPLOYER.

NOT ALL EMPLOYERS OFFER THE SAME PLAN(S).

Plan Name	Definition
DCR (Dependent Care)	This plan is for childcare that allows the parent or guardian to work.
MRA (Medical Reimbursement)	This plan is for your out of pocket medical expenses. Medical expenses are the costs of diagnosis, cure, mitigation, treatment, or prevention of disease, and the costs for treatments affecting any part or function of the body. They include the costs of equipment, supplies, and diagnostic devices needed for these purposes. They also include dental expenses. <i>(IRS Publication 502: http://www.irs.gov/publications/p502/ar02.html#d0e226)</i>
HRA (Health Reimbursement)	This plan is employer sponsored funds that can only payout to the employer's specifications. <i>(Please refer to your enrollment letter and your Summary Plan description for more details.)</i>
PKG (Parking)	This plan is for parking expenses you can only be reimbursed for the monthly amount you selected.
TRA (Transportation)	This plan is for public mass transit you can only be reimbursed for the monthly amount you selected.

Please submit your claim using one of the following methods:

Fax to: (208) 489-7658

Mail to: Xpress Flex, Attn: Claims Processing, 7025 W. Emerald St. Suite H. Boise, ID. 83704

Email: flexclaims@xpressflex.com



REIMBURSEMENT CLAIM FORM

Please attach copies of supporting documentation, **including type and date of service to**. Keep a copy of the originals. Feel free to add up amounts for the same Service Provider and list the total on one line of the form. Please refer to the **Instructions On How to File a Claim** for further information.

Questions? Call 208-489-7650

To obtain additional forms, select the Forms option at www.xpressflex.com

Employer Name

Employee Daytime Phone #:

Grid for Employer Name

() _____

Employee Last Name

Employee First Name

Social Security Number

Grid for Employee Last Name

Grid for Employee First Name

Grid for Social Security Number

Mailing Address

Street

City

State

Zip

Is this a new address?

(Check Here)

Plan Name(s):	DCR (Dependent Care)	MRA (Medical Reimbursement)	HRA (Health Reimbursement)	PKG (Parking)	TRA (Transportation)
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Please refer to your plan letter to confirm your selected plans.

For MRA and HRA, will your insurance provider cover a portion of this expense? Yes _____ No _____

Plan Name (see above)	Date or Date Range Expense(s) Incurred			Patient's Name	Type of Service	Provider Name	Amount Requested
	Month	Day	Year				

Input the total amount you are requesting for each Plan

Name in the Total area to the right →

Plan Name → _____ Total: \$ _____
 (see above)

Plan Name → _____ Total: \$ _____
 (see above)

Plan Name → _____ Total: \$ _____
 (see above)

Grand Total All Plans: \$ _____

Note: If you are claiming more items than will fit on this form, please feel free to list them on a separate sheet. However, REMEMBER that you MUST indicate the **Grand Total** on this sheet

I hereby certify that:

The above information is correct. I have not previously received reimbursement for these expenses from this plan or any other plan; and the total of any reimbursed dependent care expense does not exceed my or my spouse's earned income for the year and/or does not exceed \$5,000 (\$2,500 if I am married and file a separate tax return).

I understand that:

I alone am responsible for the sufficiency and accuracy of all information relating to this claim and that unless an expense under the Plan, I may be liable for payment of all related taxes, including federal, state, or city income tax on amounts paid from the plan that relate to such expenses.

Employee's
Signature: _____

Date: _____

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