Universal Claim Form

Step 1: Claim Information

Today's Date: _____/_____/_____                           Number of pages: ___________                                    Plan year beginning for: 20_____
New Claim                                           Resubmission of claim                         Response to claim denial

Step 2: Participant Information

*=Required Fields

*Employer Name (Do not abbreviate) Department

*Participant Name (First, Ml, Last) - - -

*Participant Mailing Address Check here if change of address Email Address (If provided, all notifications will be sent via email)

*City                                                                                                                      *State             *Zip

Step 3: Reimbursement Request

Medical Reimbursement Account   (FSA)  Adoption Assistance Reimbursement Account
Dependent Care Reimbursement Account 105(h) Health Reimbursement Account (HRA)
Individual Premium Reimbursement Account

*Employee, Spouse or Dependent Name                  *Amount Requested            *Date of Service                         *Type of Service

Total Amount Requested:       $___________

Please note the following requirements for claims submission:

• Please number each receipt according to its order of appearance on this form.
• IRS guidelines do NOT consider cancelled checks as valid documentation.
• Previous balances are NOT acceptable.
• All reimbursements will be made payable to the employee.

Minimum Reimbursement for manual claims: $25

**Sign up for Direct Deposit TODAY**

Step 4: Authorization

To the best of my knowledge and belief, my statements in this reimbursement voucher are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants. I certify that these expenses have not been previously reimbursed on this or any other benefit plan and WILL NOT BE CLAIMED AS AN INCOME TAX DEDUCTION. I authorize my account be reduced by the amount requested.

SIGNATURE OF PARTICIPANT_______________________________________________________________ DATE _____________________

Please fax this completed form to Pro-Flex Administrators, LLC: 716-929-2013 or toll free 1-855-214-8987 or mail to: Pro-Flex Administrators, LLC, 8321 Main Street, Williamsville, NY 14221
Visit our website to access account information at www.proflextpa.com