



EMPLOYER NAME _____

MEDICAL CARE EXPENSE CLAIM FORM

Social Security No: _____

Participant's Name: _____
Last First Middle

The undersigned participant in the Plan requests reimbursement in the amounts shown below: (If additional space is needed, please use an additional claim form.)

MEDICAL CARE EXPENSES

<u>Date Incurred</u>	<u>Name of Service Provider</u>	<u>General Description of Expense</u>	<u>Person for Whom Expense Incurred</u>	<u>Net Amount</u>
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
Total amount of medical expenses claimed.				\$ _____

CLAIM IS NOT BEING REIMBURSED BY INSURANCE

NOTE: Federal law requires that you **submit a written statement from an independent third party** (such as an itemized bill from the benefit provider or Explanation of Benefit statement (EOB) to be reimbursed for your expenses. Also, you will not be entitled to claim this expense as a tax deduction.

READ CAREFULLY: The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the Plan with respect to such expenses and that such expenses have not been reimbursed, or are not reimbursable, under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim that is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid from the Plan which relate to such expense. The undersigned further understands that no medical expense tax deduction is permitted for amounts for which reimbursement is made.

Employee's Signature Date _____

Adequately documented claims will be processed within five working days of receipt.

Claims may be sent to: FlexConnect, 55 W. 14th Street, Suite 101, Helena, MT 59601
Contact us at: Phone: (406) 442-3539 or (866) 640-3539 - Fax: (406) 495-3669
Visit our Website at www.insurancecoordinators.com or email us flex@icmont.com