SECURITY BENEFIT®

Questions? Call our National Service Center at 1-800-888-2461.

Security Flex 125 Program®
Medical/Dependent Care
Reimbursement Program Claim Form

Instructions

Use this form to request medical expense or dependent care reimbursement. Please type or print.

1. Complete all sections of the form and attach legible copies of itemized statements or an Explanation of Benefits from your insurance provider.
2. You must sign Section 2 of this form. If the form is not signed, your claim will not be processed.
3. Claims may be submitted by fax, email or postal mail. Please retain a copy for your records.
4. Claims must be submitted in good order prior to the run-out date in your plan.
5. **Do not use this claim form for Flex Convenience Card transactions or a claim that was submitted online.**

1. Provide Personal Information

Employer Name _____

Social Security Number_____ Daytime Phone _____

Name of Employee_____ _____ _____
First MI Last

Mailing Address_____ _____ _____ _____
Street Address City State ZIP Code

❑ Check if address change

Email Address_____

By providing an email address you consent to receive electronic communications regarding your Flexible Spending Account via email.

You are able to update your email address at www.securityflex.com or by contacting Security Benefit by phone, email, or postal mail.

2. Provide Signature

I agree:

– That this claim represents qualifying medical or dependent care expenses not covered/reimbursed by insurance.
– My signature below confirms my understanding and agreement with this requirement.
– I further understand that any claim that does not meet these requirements may result in this payment being considered a taxable payment by the IRS.
– I understand that the direct deposit arrangement will continue until Security Benefit receives written notification from me stating otherwise.
– This is to certify that I have incurred expenses that qualify for reimbursement under my employer's Security Benefit Medical/Dependent Care Reimbursement Program. None of these expenses have previously been submitted.
– I certify that these expenses will not be paid or reimbursed by any insurance company or from any other source or I may be subject to IRS fines and/or penalties of perjury. I hereby request reimbursement for these expenses to the extent allowable. I understand that at the end of the plan year all unpaid claims (even if less than $25.00) will be reimbursed in full and that any remaining fund balances at the end of the plan year will be forfeited to my employer.
– By providing an email address, I consent to receive all communications regarding this plan via email.

X_____ _____
Signature of Employee Date (mm/dd/yyyy)

Please Continue ➲

3. Provide Summary of Itemized Bills

❑ Dependent Care Expenses (DCA)

Provider Name	Dependent Name	Age	Date of Service	Requested Amount
See IRC Section 129 for qualifying DCA expenses.		**Total DCA Request**		

❑ Unreimbursed Medical Expenses (FMR/FSA)

Provider Name	Patient Name	Description of Service	Date of Service	Requested Amount
See IRC Section 213 for qualifying FMR/FSA expenses.		**Total FMR/FSA Request**		

4. Reimbursement Method

❍ Request reimbursement by direct deposit ❍ Request reimbursement by check

Please provide your bank information below if you wish to have payments from Security Benefit made by direct deposit to your bank account. If any information is missing your request may be delayed. You may also attach a void check to ensure necessary information is provided. Receipt by said bank of such credit entries shall be deemed receipt by you.

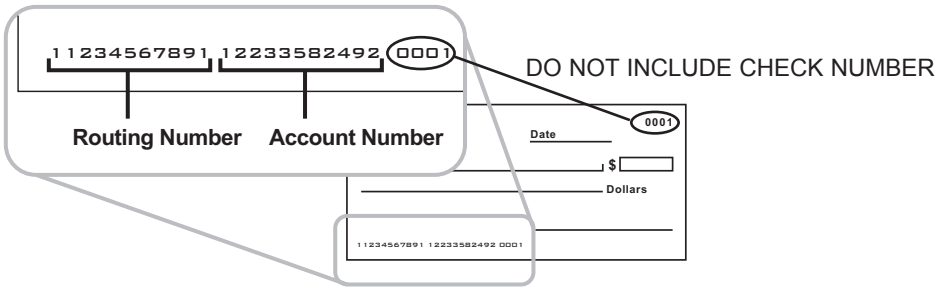
Bank Account Type (please check one): ❍ Checking ❍ Savings

Bank Name _____

Name on Bank Account _____

Bank Routing Number _____

Bank Account Number (Do not include the check number) _____



For additional information on eligible expenses you may also review the Qualified Expense Chart available on our website under the Forms section.