P.O. Box 1392
Addison, TX 75001-1292

Phone: (888) 483-1392
Fax: (888) 211-1392

Cafeteria Plan Medical and Other Insurance Claim

RESET FORM

For Accuflex Office Use:	
Date Received:	
By:	

Part 1 – Employee Information

Employer Name:	City	State
SPRINGLAKE-EARTH ISD	EARTH	TX
Employee Name:	Date of Birth:	Social Security Number:
Employee Mailing Street Address:	City:	State & Zip

Part II – Medical Expense Reimbursement Request (attach receipts)

Date	Description	Family Member	Relationship	Amount
			Total Amount Requested	**$0.00**

Part III – Other Health Insurance Reimbursement Request (attach proof of coverage)

Coverage Period		Insurance Company (or company providing coverage)	Amount
Begin Date	End Date		
		Total Amount Requested	**$0.00**

Part IV – Employee Certification for Reimbursement

I hereby certify that:

- The above information is correct; and
- I have not received reimbursement previously for these expense from my Flexible Spending Account(s) or any other plan; and

I understand that:

- Reimbursement for medical expenses (Part II) are reimbursed up to the amount of my annual election.
- Reimbursement for other health insurance (Part III) are reimbursed up to the amount of my plan-year-to-date contributions received by Accuflex.
- Reimbursement is not a guarantee that this payment is tax-free.
- Health care expenses reimbursed through this account cannot be used as a deduction on my personal income tax return.

I hereby authorize release of payment through my Flexible Spending Account(s).

I hereby authorize Accuflex Services, Inc., or its representative, to obtain necessary information from all physicians, hospitals, medical service providers, dependent care providers, pharmacists, employers, and all other organizations, including other insurers, to consider the claim for reimbursement under my Flexible Spending Account(s).

Employee Signature: _____ **Date:** _____