MEDICAL
Flexible Spending Arrangement
Claim Form

Apply expenses to the

20 ____ Plan year

Claims may be faxed to: 916-605-4013, or scanned and emailed to: claims@125max.com

Participant Data

Employer Name:	
Participant Name:	
Participant Social Security:	XXX – XX – Last four (4) digits only
Daytime Phone Number:	( ) -
Evening Phone Number:	( ) -
E-mail Address: Work ☐ Home ☐	
Change of Address: ☐	
Change of Phone Number: ☐	( ) -
Change of **e-mail** address: ☐	

Reimbursement Request

Complete the following grid for each medical expense submitted for reimbursement for you and/or your dependents. In order to receive reimbursement, appropriate supporting documentation must accompany this form. Please refer to the 125MAX Information and Instructions and the 125MAX Participant User's Guide to confirm necessary documentation, timing requirements and rules for eligible expenses.

Name of Person Incurring Expenses	Relationship to Employee	Date of Service	Name of Service Provider	Description of Medical Expense	Amount of Claim
					$
					$
					$
					$

Participant Certification

To the best of my knowledge and belief, the statements in this medical expense claim form are complete and true. I certify these expenses are for valid medical expenses provided on the dates indicated and that these expenses were incurred while I was actively participating in the 125MAX Medical Flexible Spending Arrangement. *I, the participant, certify that I have not been reimbursed for the above expense(s) and that I **will not** seek reimbursement under any other plan covering health benefits. These expenses have not been reimbursed under the 125MAXFlex Plan previously. Additionally, I will not seek reimbursement elsewhere in the future.* I understand that these expenses may not be used to claim any federal income tax deduction or credit. I understand that I alone am responsible for the sufficiency, accuracy and validity of all information relating to this claim. If any claim for reimbursement is not an eligible expense under the plan, I will be responsible for payment of all related liabilities, including federal and state income taxes and any applicable penalties resulting from improper reimbursement from the plan.

Date: / /	Participant Signature:

A photocopy of this form may be used if needed.

Be sure to include proper documentation to avoid delays in reimbursements.
*****Please do not use highlighter on any receipts*****

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