SECURITY BENEFIT℠

Security Flex 125 Program®

Medical/Dependent Care Reimbursement Program Claim Form

Please type or print in black ink. Questions? Call our Customer Service Center at 888-662-3646.

For faster processing, use our toll free fax: 866-477-6526

1. Personal Information

Social Security Number

Name of Employee
(First) (MI) (Last)

Address

City

State Zip Code

Phone Number (for confidential calls between 8:00am and 6:00pm CST)

Employer Name

2. Type of Claim

☐ **Medical Expense Reimbursement**

Requested Amount: $ _____

☐ **Dependent Care Reimbursement**

Requested Amount: $ _____

Please complete worksheet on the back of this form to itemize expenses and attach original receipts. Reimbursement requests must be at least $25.00 unless the balance remaining is less.

3. Direct Deposit Payment Option

☐ Select this option if you wish to have payments from Security Benefit made by **direct deposit** to your bank account.

Note: If this is the first time you are selecting this option – you must attach a void check below, which includes your financial institution's routing number and address.

I hereby authorize Security Benefit to initiate credit entries to my:

☐ Checking Account
Void Check Below

☐ Savings Account
Account Information Below

Receipt by said bank of such credit entries shall be deemed receipt by me.

This authority is to remain in full force and effect until Security Benefit has received written notice from me of its termination in such time and in such manner as to afford Security Benefit a reasonable opportunity to act.

4. Signatures

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.

Note: Claim form must be signed or it will be returned.

X _____
Signature of Employee

_____
Date Signed

John A. Sample
123 Same Street
Anywhere, USA 12345

0001

Pay To The Order Of _____ $ _____

_____ DOLLARS

Tape Your Void Check Here!
(DO NOT STAPLE)

For _____ VOID

112345678911223358249 2 0001

Savings Account Information

Transit Routing # _____

Account # _____

This worksheet is **optional** and available to you to help you organize your expenses you are submitting to your Medical Flexible Spending Account. All five of these items are required to be on your statements that you are submitting for reimbursement. Please attach your receipts with this claim form. **Make sure you have signed your claim form on the reverse of this worksheet.**

Name of Physician, Hospital Pharmacy or other Provider of Service	Description of service, if drug include name, days supply and quantity	Patient Name	Date of Service	Amount of Charge

Eligible expenses generally include health care expenses that are not covered, or only partly covered, by your health plans or, if you're married, by your spouse's health plans. Some of the expenses you can claim are:

Deductibles and co-payments under medical, dental, and prescription drug plans; Expenses for medical services or supplies not covered by your plans (for example, many plans do not cover routine physical or well-child care); Vision care expenses, including eye exams, eyeglasses, as prescribed by your doctor, and materials and equipment needed for using the eyeglasses such as eyeglass cleaner, contact lenses and contact lens supplies; Lasik, Laser eye surgery and Radial keratotomy; Hearing care expenses, including hearing exams and hearing aids; Expenses in excess of medical or dental plan limits (for example, orthodontic expenses greater than the limit set by your dental plan); Transportation expenses related to medical care; Nursing services not covered by your medical plan; Wheelchairs and crutches; Capital expenses for a personal residence to accommodate a disabled condition less the increase in your property value; Pregnancy test (over the counter); Certain over the counter drugs; Over the counter reading glasses when accompanied by a prescription; Smoking cessation program; Weight loss program when it is prescribed by your doctor for a specific diagnosis.

Expenses that are not Eligible

Most cosmetic surgery; Health club dues; Electrolysis; Over the counter vitamins, even when prescribed by a physician; Dietary supplements; Teeth whitening products; Insurance Premiums of any nature.

For expenses that are not listed you can refer to IRS Section 213 for more complete information or contact Security Benefit at 888-662-3646.

Mail to: Security Benefit • PO Box 750600 • Topeka, Kansas 66675-0600 or
Fax Toll Free to: 866-477-6526 • www.securityflex.com