2019 FLEX HEALTH-MEDICAL CARE

SECTION 125 – FLEX REIMBURSEMENT CLAIM FORM

HOW TO FILE A CLAIM

1) For out-of-pocket insurance expenses (for example deductibles, co-insurance) copies of the Explanation of Benefits or worksheet from your Health/Dental plan(s).
NOTE: If you or a dependent are covered by two health plans, attach the Explanation of Benefits worksheet from both plans to claim the amount not paid by either plan.

2) For other items considered reimbursable by the IRS, copies of itemized receipts obtained from the provider of the services. If you are reimbursed from another source, please include proof of reimbursement when submitting your claim.

3) **Mail your claim to: Sunwest Employer Services**
1430 E. Missouri Avenue **Phone: 602-386-3544**
Suite B-155
Phoenix, AZ 85014
Or
Upload your completed form to: https://sunwestes.sharefile.com/r-r25a9b67113345cca

ABOUT YOU

Employer's Name _____Sunwest Employer Services, Inc._____

Your Name _____

Your Address _____

_____

Social Security Number_____

HEALTH CARE INFORMATION

Patient: ☐ You ☐ Spouse Name: _____ Date of Birth: _____

☐ Child Name: _____ Date of Birth: _____

☐ Child Name: _____ Date of Birth: _____

Date of Service:	***Provider:***	***Type of Service:***	***Amount:***

PAYMENT AUTHORIZATION

I request payment from my Reimbursement Account for the expenses itemized above and attached. I understand that the expenses reimbursed cannot be claimed on my personal income tax return. I certify that the expenses above have not and will not be paid by any other plan or program of any employer or other person.

Employee Signature _____ Date _____

For additional information, please refer to the Department of the Treasury, Internal Revenue Service, Publication 969, Health Savings Accounts and Other Tax-Favored Health Plans.