HealthComp

FLEXIBLE BENEFITS PLAN CLAIM FORM

Instructions

√ Email to **HealthComp_Receipts@alegeus.com**; or mail to: HEALTHCOMP, P. O. Box 45018, Fresno, CA 93718-5018; or Fax to: Flexible Benefits Dept. 1-855-898-2719.

√ Complete the appropriate spaces on this form and attach photocopies of applicable Explanation of Benefits or receipts reflecting date of service, the person receiving the service, type of service. Incomplete claims or without proper attachments will be denied.

√ Cancelled checks or balance due statements are not acceptable bills.

√ You will have a run-out period after the Plan year ends to submit expenses incurred during the Plan Year. Please review your Summary Plan Description for your run-out period.

Employee Information

Employer's Name		
Employee's Name (Last, First, MI)		Social Security Number
Employee's Address *If change of address, check box→* ☐		City, State, Zip Code
Home Phone Number	Work Phone Number	Email Address

Claim Information – Unreimbursed Medical Expenses

	Date of Service	Name of Provider	Recipient of Services		Claim Amount
			Name	Relationship	
1.					$
2.					$
3.					$
4.					$
5.					$

Grand Total: $

Claim Information – Dependent Care Expenses (Day Care Expenses)

	Date of Service(s) From and To		Name of Provider and SS#/EIN#	Recipient of Services			Claim Amount
				Name	Relationship	Age	
1.							$
2.							$

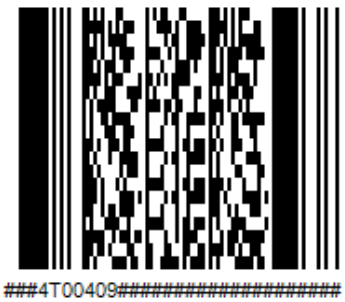
Dependent Care Provider's Signature: **Date:**

Grand Total: $

Certification – Read Carefully

The undersigned participant in the Flexible Benefits Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form, were incurred (i.e., services were provided) while the undersigned was covered under the Employer's Flexible Benefits Plan and that such expenses have not been reimbursed, or are not reimbursable, under any other health plan coverage. The undersigned understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid from the Plan which relate to such expense. The undersigned further understands that no medical expense tax deduction or dependent care tax credit is permitted for amounts for which reimbursement is made.

Employee's Signature: _____ **Date:**_____



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