TerrillFLEX

Request for Reimbursement

Employee Information

Employer _____ Daytime Phone _____

Employee name _____ SSN _____-_____-_____
Last First M

Home address _____
Street City State Zip

☐ Check box to indicate new address Email address _____

To the best of my knowledge and belief, my statements in this Request for Reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred by me or my eligible dependents during the applicable plan year. I certify that these expenses have not been previously reimbursed under this or any other benefit plan, and will not be claimed as an income tax deduction.

_____ Date _____
Employee Signature (required) ***(required)***

Health Care Account

For expenses covered by any health insurance plan, attach a copy of insurance Explanation of Benefits (EOB). For expenses **not** covered by insurance, attach a copy of appropriate bills. Do **not** include any amounts paid or eligible for payment under any other health care plan or program, federal, state, or governmental program, workers' compensation or other policy of health insurance. Expenses must be incurred during the plan year and while you are active in the plan.**Credit card receipts, canceled checks, and balance forward statements are not acceptable receipts.**

Patient Name	Relationship	Date(s) of Service	Service Provided	Eligible Reimbursement Amount
				$
				$
				$
				$
				$
				$
			TOTAL	$

Dependent Care Account

Attach a copy of the statement from the child/elder care provider indicating the dates of service and the charge, OR the provider may sign in the box below. The following information is REQUIRED: Provider's Name, Address, and Taxpayer ID # (or SS#). **Canceled checks and credit card receipts are not acceptable receipts.**

Dependent Name	Dependent Birthdate	Relationship	Date(s) of Service	Provider Name, Address, Taxpayer ID/SS#	Eligible Reimbursement Amount
					$
					$
					$
					$
					$
					$
				TOTAL	$

Provider Signature _____

Mail claims to:
TerrillFLEX
825 Maryville Centre Drive, Suite 200
Chesterfield, MO 63017

Fax claims to:
1-866-731-9932
info@terrillflex.com

All claims must be submitted 48 hours prior to the groups disbursement day.

By Email:
info@terrillflex.com

By Phone:
Phone: 1-866-422-8250
Fax: 1-866-731-9932

You must indicate the dollar amounts you are asking to be reimbursed from your FLEXPAY account(s).

Expenses paid from your FLEXPAY reimbursement account(s) cannot be claimed as income tax deductions.

You will receive an explanation of the claims paid and your remaining account balance(s) on your FLEXPAY reimbursement check stub.

Canceled checks, credit card receipts, and balance forward statements are not acceptable receipts for either reimbursement account.

Health Care Reimbursement Account:

All receipts MUST include: provider name, patient name, service provided, date of service, and charge for the service. For prescription claims, submit the Pharmacy receipt you receive from the pharmacist that indicates the name of the drug.

Attach a copy of the Explanation of Benefits or denial letter from your insurance carrier or another third-party payer.

Reimbursement for health care expenses can be made for more than your current account balance, but cannot exceed your annual election amount.

Dependent (Child/Elder) Care Reimbursement:

Care must be for an eligible dependent ***under age 13*** or for a spouse or other eligible dependent that is physically or mentally incapable of caring for himself/herself.

Attach an invoice or receipt for charges incurred including dates of service from the day care center or individual that provides the care. **The day care center's taxpayer ID# or the individual's social security number and the service dates are required**.

If the provider cares for more than six children (not counting his/her own), he/she must be licensed by the State to qualify for FLEXPAY reimbursement.

The individual who provides the care cannot be your spouse or your child under age 19.

Reimbursement for dependent care expenses will not be made for more than your current account balance. If your expenses total more than your account balance, you will be reimbursed for the amount that is in your account and the balance of the claim will be paid as future deposits are added to your account for that Plan Year. **Maximum election allowed is $5,000 per household per year (married filing a joint return), or $2,500 if married filing a single return**.

Submit your claim to the address on the front of this form. If you have questions, please contact the TerrillFlex team at:

By Email:
info@terrillflex.com

By Phone:
Phone: 1-866-422-8250
Fax: 1-866-731-9932

Please keep a copy of all claims for your records