FlexPro™ Claim Form

THIS FORM MUST ACCOMPANY EACH GROUP OF RECEIPTS SUBMITTED

Employer Name: **BALL STATE UNIVERSITY**

Employee Name: _____ ID or SSN Number: _____

Home Address: _____
Number & Street **City** **State** **Zip Code**

Day Time Phone Number: _____ Number of pages: _____

☐ Please check if new address

To the best of my knowledge and belief, my statement in this Request for Reimbursement is complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants. If this claim includes medical expenses, I certify that these expenses have not been reimbursed, are not reimbursable from any other source, nor will any reimbursement be sought from any other source. I authorize my Flexible Spending Account(s) be reduced by the amount requested.

Employee Signature: _____ Date: _____
Signature Required

Health Care Expenses:

Expenses that may be covered by your (or your spouse's) medical, dental or vision plan must first be submitted to the appropriate insurance carrier. The Explanation of Benefits (EOB) you receive from your insurance carrier may then be submitted to *FlexPro*™ as a qualifying receipt towards your *FlexPro*™ Plan. Health care receipts must be from an independent third party and must include the Name of the Patient, Name of the Provider, Type and date of Service or Supply provided (Names of Prescriptions are required), and the Amount of the Service or Supply. Receipts for eligible over-the-counter drugs or medicines must include the same information but the type of Supply and the Patient's Name may be hand written on the receipt by the participant if necessary.

Name of Patient or Dependent	Date(s) Of Service	Name of Provider or Merchant	Type of Service or Supply	Health Care Charge for each service/supply	Debit Card Purchase Substantiation
					☐
					☐
					☐
					☐
					☐
			TOTAL		

If necessary please add additional page:

Dependent Care:

Dependent Day Care receipts must include the Name of the Provider, Dates of Service, Name of the Dependent(s), Fee for Service or you may have your Dependent Day Care Provider complete and sign below (Original Signature required).

Date(s) of Service: _____ Fee for Service: _____

Dependent(s) Name: _____ Dependent Date of Birth: _____

Day Care Provider Name: _____ Tax ID/SS# _____

Day Care Provider Signature: _____ Date: _____

Attention MBI Benefits Card Users:

- ☐ None of the attached claims were purchased using my MBI Benefits Card.
- ☐ Some of the claims were purchased using my MBI Benefits Card. Please check claim(s) purchased with your Benefits Card.
- ☐ All of the attached claims were purchased using my MBI Benefits Card.

The following reimbursement request rules apply: Health Care and Dependent Care expenses must be incurred within the appropriate Plan Year. See Plan Specific page for eligibility requirements. Photocopies of receipts are acceptable. Please retain a copy of all receipts for your own records. *Cancelled checks are not acceptable receipts*. This form must be signed and submitted with applicable receipts.

Key Benefit Administrators, Inc. P.O. Box 55210 Indianapolis, IN 46205

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