

Insurance Premium Expense Claim Form

FAX: 1-888-207-2310

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To make a claim for reimbursement of your **individual insurance premium expenses**, please complete this form and attach copies of your payment coupons or insurance billing statements along with proof of payment of the insurance premiums, such as copies of canceled checks or your bank statement showing automatic fund withdrawals by your insurance carrier. Please note that you cannot be reimbursed for your employer's group insurance premiums deducted out of your paychecks.

Mail your claim and documentation to:

FlexToday, Inc.
PO Box 16099
Fresno, CA 93755

PLEASE READ AND SIGN BELOW

I hereby understand, certify and agree that: The expenses submitted for reimbursement have not been reimbursed or paid previously and I will not seek payment or reimbursement under insurance or other benefit plan for these expenses; These expenses were incurred during the coverage period by either me or my eligible dependents; I assume the responsibility to maintain substantiating documents for all claims; I am fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim; I am liable for payment of any taxes and penalties, federal, state or local, related to expenses claimed or paid that are not eligible expenses under the Plan(s); These expenses cannot be claimed as credits or deductions on my personal tax return if reimbursed or paid from the Plan(s); I certify and agree that the reimbursement of these premium expenses from my employer's plan does not indicate or cause my individual policy(ies) to be or be considered a an Employer-sponsored group health plan; I have received a copy of the Summary Plan Description(s) and understand that this claim is subject to the terms and requirements of the Plan(s), including but not limited to eligibility, coverage period and claims filing deadlines; I may receive notifications by email instead of mail and I understand that I must notify FlexToday in writing to rescind this authorization to send notifications by email; and, My digital signature on this form will be accepted as binding with the same weight and consideration as a pen and paper signature.

Please complete the entire form before clicking "sign here." The form will lock after signing and cannot be reopened. Digital signature requires full Adobe Acrobat program (digital signature isn't available with Adobe Reader.)

Sign Here

Date Signed

REQUIRED	Employer/Plan Sponsor		
	Your Name		
	Address		
	City, State and Zip Code		
	Email Address		
Your email address and the answers to the items below are required for us to accept a digital signature on this form.			
Last 4 # of EE SSN	Full Date of Birth	Phone Number	

Total Insurance Expenses Claimed With This Request: \$ _____

Name of the Insured Person	Relationship to Employee	Dates of Coverage	Name Of Insurer	This is my cost for this service
				\$
				\$
				\$
				\$
				\$

FlexToday, Inc. • 191 W Shaw Ave Ste 101 • Fresno, CA 93704 • Ph: 559-432-6800 or 800-995-5373
Claims Fax 1-888-207-2310 • Alternate Fax 1-469-398-0423 • **Secure Claims Portal Link**

You can send claims to us by fax, mail or electronically (scanned) at the Secure Claims Portal. **We do not accept claims by email.** The "digital signature" feature is only available if you have Adobe Acrobat (6+); the digital/electronic signature is not available with Adobe Reader. Claims sent to the Secure Claim Portal should be in Adobe ".pdf" format. If your claim requires multiple Adobe files, the files must be named similarly and numbered (001, 002, etc.). **PLEASE identify yourself in the "Add A Message" box.** Unidentified files and files sent in any format other than Adobe ".pdf" may be unacknowledged and will not be treated as an actual claim submission. Files or links sent to the Portal in executable formats (.exe, .zip, .eml, .com, .net, .html, vbs, etc.) will be deleted without opening or notice.