

# Individual Premium Reimbursement Request

Please complete this form and sign and date as shown below. Attach copies of the Insurance Premium billing statement and proof of payment of the premiums. If you have your premiums deducted directly out of your bank account, you can provide a copy of your bank statement as proof of the insurance premium payments. Keep the copies of your claim and supporting documentation for your records as we cannot provide copies of your claims.

Mail your claim and supporting documents to:  
FlexToday, Inc.

Fax Number:  Fax Page # _____ of _____
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Personal Information – Must Complete Each Claim	<b><i>SIGN BELOW – SIGNATURE REQUIRED</i></b>				
Name of Employer	I, the undersigned, request reimbursement for the expenses submitted herein and certify that these expenses herein have not been reimbursed previously and I will not seek reimbursement under any other insurance or benefit plan for these expenses. I further certify that these expenses were incurred (services received, not necessarily paid) during the coverage period by either myself or my eligible dependents for eligible expenses under the Plan as described in the Summary Plan Description and as defined by all applicable state and federal laws. I assume the responsibility to maintain substantiating documents for all claims submitted for reimbursement. The Administrator shall have no obligation to any Participant for any act or failure to act, provided the Administrator has acted in good faith in the exercise of its powers in the Plan.				
Your Full Name – (First and Last)					
Address					
City, State and Zip Code					
Is this a new address?                      Yes                      No					
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 5px;">Phone Number</td> <td style="width: 50%; padding: 5px;">Social Security Number</td> </tr> </table>		Phone Number	Social Security Number		
Phone Number		Social Security Number			
Your E-Mail Address					
<table style="width: 100%;"> <tr> <td style="text-align: center; color: red; font-weight: bold; font-size: 1.2em;">Sign Here</td> <td style="text-align: right; font-weight: bold;">Date Signed</td> </tr> <tr> <td style="text-align: center; border-top: 1px solid black; padding-top: 5px;">X _____</td> <td></td> </tr> </table>		Sign Here	Date Signed	X _____	
Sign Here	Date Signed				
X _____					

**Total Premium Expenses Claimed With This Request: \$ \_\_\_\_\_**

Name of Person Insured	Relationship to Employee	Insurance Coverage Period	Premium Cost
			\$
			\$
			\$
			\$
			\$