Flexible Benefit Plan

HEALTHCARE EXPENSE CLAIM FORM

Soc Sec or
Employee No: ____________________ **Printed Name:**____________________________

The undersigned participant in the plan requests reimbursement (attach itemized bill, detailed receipt, invoice and/or EOB for all expenses listed below) in the amounts shown below: (If additional space is needed, please use back of form.)

Mail, Fax or Email to: HealthCare Solutions Group, Inc.
P.O. Box 1309
Muskogee, OK 74402
Fax: (918) 781-4979
Email: ctremblay@hsg.com

MEDICAL CARE EXPENSE

DATE INCURRED	NAME OF PROVIDER	FAMILY MEMBER	AMOUNT
________________	_____________________	___________________	__________
________________	_____________________	___________________	__________
________________	_____________________	___________________	__________
		TOTAL	__________

READ CAREFULLY

The undersigned participant in the plan certifies that all expenses for which reimbursement or payment claimed by submission of this form were incurred during a period while the undersigned was covered under the (insert Employer's name) ______________________________ Flexible Benefit Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any health plan coverage. The undersigned fully 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 expense under the Plan, the undersigned may be liable for payment of all taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

Date: ______________ Employee Signature: ______________________________

HSG use only:

Payment authorized ____________________ *Amount* ___________________