KAPNICK INSURANCE GROUP

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Tel (800) 550-3539
Fax (517) 264-6172
E-mail flex@kapnick.com

FLEXIBLE BENEFIT REIMBURSEMENT REQUEST FORM

EMPLOYEE INFORMATION

Employee's Name: _____ (Last) _____ (First)

Social Security # XXX - XX - _____

Employer's Name: _____

Your Daytime Phone: _____

MEDICAL CARE

Name of Family Member Expense Covers	Description of Expense	Date of Service	AMOUNT

(List additional items *on* separate sheet) **TOTAL EXPENSES** $

WILL ANY OF THE ABOVE EXPENSES BE COVERED OR REIMBURSED FROM ANY OTHER SOURCE (e.g., Blue Cross, an HMO, another Employer's Insurance Company)? ☐ NO ☐ YES *If yes, you MUST attach copies of the other plan's explanation of benefits form.*

DEPENDENT CARE

Dependent's Name	Date of Birth	New or Temporary Service Provider's Name, Address and Tax I.D. Number	For Dates From	To	AMOUNT

(List additional items on separate sheet) **TOTAL EXPENSES** $

Please have your dependent care provider complete the following if no statement is attached.

I certify that the above charges are accurate and the services were provided during the dates indicated.

_____ Dependent Care Provider Signature

_____ Dependent Care Provider Soc. Sec. or Tax ID#

ACKNOWLEDGMENT AND SIGNATURE

I certify that there are no false statements on this form. I understand that this plan is subject to provisions of several Internal Revenue Code Sections and that all tax consequences of this plan are my sole responsibility. Also, I certify that the expenses that I am submitting are not reimbursable under any other benefit plan.

Signature _____ Date _____

How to Use Your Reimbursement Account

Claim Form Instructions

The following instructions deal with claim procedures that will enable you to submit claims for payment from your reimbursement account(s). Occasionally a question may arise about payment of your claims. If so, feel free to contact Kapnick Insurance Group at 1-800-550-FLEX (3539).

How to Prepare a Claim for Medical Reimbursement

You should complete the *Employee Information* section of the Flexible Benefit Reimbursement Request Form, indicating your name, social security number and company name.

You should attach an itemized billing for each claim. Each billing must include the name of the patient, diagnosis, nature of services or supplies furnished, dates of services, and amount charged for each. It must also contain the provider's (e.g. doctor's) name and address. If you are covered under an HMO, please submit the receipt (original or copy) for office visits or prescription drug co-payments.

If you have medical, dental or vision coverage through a traditional group health plan, you may provide an explanation of benefits statement (EOB) showing what the insurance carrier has paid on charges. If you do submit an explanation of benefits form, you are not required to submit the original invoice for service(s).

If you have medical, dental or vision care expenses which are not eligible for reimbursement under any insurance plan, you may submit the itemized statement and note that this expense is not covered under you insurance plan.

How to Prepare a Claim for Dependent Care Reimbursement

You should complete the *Employee Information* section of the Flexible Benefit Reimbursement Request Form, indicating your name, social security number and company name.

You should complete the *Dependent Care* section of the Flexible Benefit Reimbursement Request Form and attach an itemized statement with each claim. Each statement must show the dates that the dependent care was rendered and the amount charged for this service. It must also contain the provider's name and social security number or tax identification number. If your provider is unable to prepare a statement with the requested information, you may have your provider sign and date the statement in the dependent care section.

How to Complete and Send in Your Form

Lastly, you need to sign and date the form and forward the completed claim form and all bills to Kapnick Insurance Group. **Please staple your receipts, invoice or explanation of benefits to the Flexible Benefit Reimbursement Request Form.**

Claims may be: 1) emailed to flex@kapnick.com; 2) faxed to (517) 264-6172; or 3) Mailed to Kapnick Insurance Group, 333 Industrial Dr., P.O. Box 1801, Adrian, MI 49221-7801

Kapnick Insurance Group will attempt to process your claim within five (5) business days. Please allow time for mail. Reimbursement checks will be mailed directly to your home and are not available for pick-up from our claim office.