



FLEXIBLE SPENDING CLAIM FORM

Please Print

Employer _____

Your Name _____ ID # _____

My address has changed. My new address is _____

Medical/Dental Expenses

Medical/Dental expenses covered under an insurance plan must be submitted to the insurance carrier first.

****You should NOT use this form to submit documentation to substantiate expenses charged under your MBI card.** For expenses charged under the MBI card, simply attach the documentation substantiating the charges to the letter you may receive either in the mail or from flexiblepending@somi.LHIOD.com. It is possible that you may not have to submit documentation for some types of expenses charged under the MBI card.

In order to process your claim we must receive proper documentation. To process your expense(s) we must receive receipts, billing statements, explanation of benefits, or letters of benefit denial. They must be itemized and include the incurred dates of service.

Balance due statements and canceled checks are not acceptable. Refer to your FLEXIBLE BENEFIT booklet for a list of eligible expenses.

This entire form must be completed in order for us to process your claim. Please check the appropriate box, complete the rest of the form and send to: Sheffield, Olson & McQueen at the address shown above.

___ *The charges I am submitting have already been processed by my insurance carrier. **ATTACHED SECURELY ARE:** My Explanation of Benefits, letters of benefit denial, or receipts for co-payments.*

___ *I certify that the charges I am submitting are not covered under any insurance plan or policy. **ATTACHED SECURELY ARE:** Itemized bills for those charges **NOT** covered by any other plan.*

Date of Service	Person Receiving Service (Self, Spouse, Dependent)	Type of Expense (Check One)				Total Expenses	Amount Paid By Insurance	Amount To Be Paid From Your Flex Account
		Vision	Medical	Drugs	Dental			
				Totals	\$		\$	

I hereby certify that the information shown above is true and correct, and that neither I, my spouse, nor any of my eligible dependents have or will receive reimbursement for any of the expenses listed above from any other source, and furthermore, that I have not, and will not, claim any of these expenses as a deduction on, or in calculating a credit for, my/my spouse's income taxes. In addition, I certify that the "Person Receiving Service" listed above is eligible to be covered under the Plan.

Signature _____ Date _____