Health FSA
Expense Claim Form

Employee Data

Company Name:

Employee Name:

Employee ID (Last 4 of SSN):

Plan Year:

Reimbursement Request

Complete the following grid for each health expense submitted for reimbursement. In order to receive reimbursement, appropriate supporting documentation must accompany this form. Please refer to the Vita Flex Information and Instructions or your Plan Information to confirm necessary documentation, timing requirements, and rules for eligible expenses. You can also visit our website at help.vitacompanies.com.

Patient Name	Date of Birth	Relationship to Employee	Date of Service	Name of Service Provider	Type of Service	Amount of Claim	Debit Card*
						$	☐
						$	☐
						$	☐
						$	☐
						$	☐
						$	☐

Check box only if receipts submitted are intended to document purchases already made with your **Vita Flex debit card.*

Verification

To the best of my knowledge and belief, the statements in this health expense claim form are complete and true. I certify these claims are for valid health expenses provided on the dates indicated and that these expenses were incurred while I was actively participating in the Vita Flex Medical Reimbursement Plan, and that these expenses are incurred by an eligible participant under the plan (either myself as the eligible employee or an eligible dependent according to the guidelines of the plan). *These expenses have not been reimbursed under the Vita Flex plan previously nor have they been reimbursed under any other health plan. Additionally, I will not submit these expenses for reimbursement under any insurance plan or from any other source.* I understand that these expenses may not be used to claim any federal income tax deduction or credit. I understand that I alone am responsible for the sufficiency, accuracy and validity of all information relating to this claim. If any claim for reimbursement is not an eligible expense under the plan, I will be responsible for payment of all related liabilities, including federal and state income taxes and any applicable penalties resulting from improper reimbursement from the plan.

Date **Employee Signature**

New Phone/Address (Complete Only if Needed)

New Email Address:

New Home Address:

Online:
www.vitaflex.net

Fax:
Vita Flex Claims Dept.
(650) 964-FLEX (3539)
(866) 964-FLEX (3539)

E-mail:
claims@vitamail.com

Mail:
Vita Flex Claims Dept.
900 North Shoreline Blvd.
Mountain View, CA 94043

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