COMMUNITY CARE MANAGEMENT SRVCS, INC.

DEBIT CARD VALIDATION CLAIM FORM

Flexible Benefit Group
1575 Redbud Blvd., Suite 100
McKinney, Texas 75069
Voice: (972) 991-3539 or (800) 249-9970 Fax: (972) 991-5155 Email: fbgfax@flexiblebenefitgroup.com

Employee's Name **Soc. Sec. #**

Street **City** **State** **Zip**

FLEX-MED EXPENSES (for employee and/or IRS claimable dependent)

I hereby file claim for the medical expenses noted below. I certify that each expense had service rendered on the date and for the person and reason noted and is not reimbursable by insurance. Attached are receipts or other evidence of my having had service rendered for these expenses during the plan year. These expenses are for myself or my dependent that I claim as a dependent on my income tax. I understand that my employer has the right to verify these expenses.

Date of Service	Person Treated	Nature of Expense	Amount of Expense
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
		Total FLEX-MED Expenses Claimed	$

IMPORTANT NOTE: CREDIT CARD RECEIPTS & CANCELLED CHECKS DO NOT QUALIFY AS A RECEIPT

I UNDERSTAND THAT THE DEBIT CARD IS RESTRICTED TO CERTAIN MERCHANT CATEGORIES AND IS NOT ACCEPTED AT ALL MASTERCARD ACCEPTANCE LOCATIONS. I ALSO UNDERSTAND THAT I MAY NOT OBTAIN A CASH ADVANCE WITH THE CARD AT ANY MERCHANT, BANK OR ATM. THE DEBIT CARD IS TO BE USED EXCLUSIVELY FOR QUALIFIED EXPENSES AS DEFINED BY THE PLAN(S) IN WHICH I PARTICIPATE. IF THE CARD IS ISSUED PURSUANT TO THE EMPLOYER PLANS AND I USE THE CARD FOR AN EXPENSE THAT IS NOT A QUALIFIED EXPENSE, I AM INDEBTED TO MY EMPLOYER AND MUST REPAY THE FULL AMOUNT OF THE NON-QUALIFIED EXPENSE. I AGREE TO SAVE ALL INVOICES AND RECEIPTS RELATED TO ANY EXPENSE PAID WITH THE CARD; UPON REQUEST (BY E-MAIL OR PHONE) I MUST SUBMIT THESE DOCUMENTS FOR REVIEW BY THE PLAN SERVICE PROVIDER (FBG).

FAILURE TO SUBMIT RECEIPT(S) WILL CAUSE THE EXPENSE TO BE TREATED AS A NON-QUALIFIED EXPENSE AND I WILL BE REQUIRED TO REMIT PAYMENT TO MY EMPLOYER. PAYMENT MAY BE IN THE FORM OF AN OFFSETTING CLAIM, A PERSONAL CHECK, ELECTRONIC DRAFT FROM YOUR PERSONAL CHECKING OR SAVINGS ACCOUNT, A POST-TAX DEDUCTION FROM YOUR PAYCHECK, OR OTHER OPTIONS ESTABLISHED BY YOUR EMPLOYER.

SIGNATURE REQUIRED **Date:**

Please Note: Signature of employee required for payment from Flex-Med Account.