



FLEX HEALTH-MEDICAL CARE

SECTION 125 - REIMBURSEMENT CLAIM FORM

**HOW TO FILE
A CLAIM**

- 1) For out-of-pocket insurance expenses (for example deductibles, co-insurance) copies of the Explanation of Benefits or worksheet from your Health/Dental plan(s).
NOTE: If you or a dependent are covered by two health plans, attach the Explanation of Benefits worksheet from both plans to claim the amount not paid by either plan.
- 2) For other items considered reimbursable by the IRS, copies of itemized receipts obtained from the provider of the services.
- 3) **Mail your claim to:** **IPMG Employee Benefits Services** **Fax:** 630-203-4580
225 Smith Rd.
St. Charles, IL 60174
Phone: 630-789-2082
Website Submittal and/or E-mail:
www.ipmg.com/ebs

ABOUT YOU

Employer's Name _____

Your Name _____

Your Address _____

Phone #/E-mail _____

Your Alternate-ID* or Social Security Number _____

*Your Alternate-ID is assigned by IPMG

**HEALTH CARE
INFORMATION**

Patient: You Spouse Name: _____ Date of Birth: _____

Dependent Name: _____ Date of Birth: _____

Dependent Name: _____ Date of Birth: _____

Date of Service:	Provider:	Type of Service:	Amount:

**PAYMENT
AUTHORIZATION**

I request payment from my Reimbursement Account for the expenses itemized above and attached.
I understand that the expenses reimbursed cannot be claimed on my personal income tax return.
I certify that all of these expenses have not and will not be paid by any other plan or program of any employer or other person.

Employee Signature _____ Date _____