# HEALTH EXPENSE Claim Form

***Health Flexible Spending Arrangement (Health FSA)***

**Contact 125MAX LLC at: 916-605-4030 or 800-843-6608**
**Claims may be faxed to: 916-605-4013, or scanned and emailed to: claims@125max.com**
**or Mailed to: 125MAX LLC, 35 Iron Point Circle, Ste. 100, Folsom, CA 95630**

## PARTICIPANT PERSONAL INFORMATION

| | |
|---|---|
| **Employer Name**: | |
| Participant Name: | |
| Participant Social Security: | XXX – XX – Last four (4) digits only |
| Daytime Phone Number: ☐ Changed | ( ) - |
| Evening Phone Number: ☐ Changed | ( ) - |
| Email Address: ☐ Work ☐ Home ☐ Changed | |
| Home Address: ☐ Changed | |

## REIMBURSEMENT REQUEST INFORMATION

**Complete the following grid for each medical expense submitted for reimbursement for you and/or your dependents. In order to receive reimbursement, appropriate supporting documentation must accompany this form (examples: your insurance explanation of benefits (EOB), detailed provider bill showing dates of service, etc.) Contact 125MAX with questions, to confirm necessary documentation, timing requirements, and rules for eligible expenses. If you are claiming any medical mileage, please complete and attach the Medical Mileage Report form.**

| Name of Person Incurring Expenses | Relationship to Employee | Date of Service | Name of Service Provider | Description of Medical Expense | Amount of Claim |
|---|---|---|---|---|---|
| | | | | | $ |
| | | | | | $ |
| | | | | | $ |
| | | | | | $ |
| | | | | | $ |
| | | | | | $ |
| | | | | | $ |
| | | | | | $ |

## PARTICIPANT CERTIFICATION

**To the best of my knowledge and belief, the statements in this medical expense claim form are complete and true. I certify these expenses are for valid medical expenses provided on the dates indicated and that these expenses were incurred while I was actively participating in the 125MAX HEALTH FSA. *I, the participant, certify that I have not been reimbursed for the above expense(s) and that I will not seek reimbursement under any other plan covering health benefits. These expenses have not been reimbursed under the 125MAXFlex Plan previously. Additionally, I will not seek reimbursement elsewhere in the future.* 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: | Participant Signature: |
|---|---|

➢ ***Please do not use highlighter on any receipts*** ➢
➢ ***Be sure to include proper documentation to avoid delays in reimbursements*** ➢
➢ ***A photocopy of this form may be used if needed*** ➢

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