Vantage Flex LLC

Request for Reimbursement

413 10th Avenue Menominee MI 49858
Phone: (800) 871-9011 / (906) 863-3539

Fax Claims to: (866) 511-5503

Employer Name:	
Employee Name:	SSN:
Email Address:	
Address:	

Section 125 Flex Plans
FSA - Medical Claim
DCA - Dependent Care Claim

Qualified Transportation
Parking
Transit / Vanpooling

Health Reimbursement Accounts
HRA – Medical Claim

Name Self / Spouse / Dependent	**Date of Service** From - To	**Description**	**Dollar Amount**	**From Account** (HRA- FSA- DCA - Parking Transit)
	-		$	
	-		$	
	-		$	
	-		$	
	-		$	
	-		$	
	-		$	
	-		$	
		Total:	$	

To the best of my knowledge and belief, my statements in the requested expenses are complete and true. I am requesting reimbursements only for eligible expenses incurred during the applicable plan year for myself and my eligible dependents. I certify that these expenses have not been reimbursed and that I shall not seek reimbursement under any other employer sponsored benefit plan and will not be claimed as an income tax deduction. Also, I certify that these expenses have not been previously reimbursed under this plan. I authorize that my plan account may be reduced by the amount of the requested reimbursement.

Note

Please provide proof of expense of any requested amount. The proof must include the date of service, service provided, the amount incurred, and whom the services were provided to.

_____ _____/_____/_____
Employee Signature Date