Submit Claims to:
CompLink Cafeteria Plan Services
P.O. Box 227197
Dallas, Texas 75222
Toll Free Fax: 1-888-866-3312
Toll Free Telephone: 1-866-279-8385

COMPLINK
FLEXIBLE BENEFITS
MEDICAL REIMBURSEMENT FORM

PART 1 – EMPLOYEE INFORMATION

Employer Name		
Employee Name	Social Security Number	
Street Address (include apartment number)		Daytime Phone Number
City	State	Zip Code

☐ **Check here if address has changed**

PART 2 – CLAIM INFORMATION

Total health expenses incurred	$
Benefit payable by your or your spouse's employer's insurance plan	$
Balance to be considered under the Flexible Benefits Plan	$

CLAIM DOCUMENTATION IS REQUIRED!

☐ **I have attached copies of Explanation of Benefits (EOBs) for deductible and coinsurance requests.**

☐ **I have attached itemized bills for expenses not covered by medical, dental or vision insurance.**

FAILURE TO PROVIDE THE ABOVE INFORMATION MAY DELAY PAYMENT OF CLAIM.

PART 3 – EMPLOYEE CERTIFICATION

I certify that all items I am requesting to be reimbursed are eligible health care expenses under the Internal Revenue Code and my employer's Flexible Benefits Plan. Such items have not and will not be covered by any other plan or program of any employer or other person. My employer does not accept responsibility for direct payment to any individuals other than the employee.

_____ _____

Employee Signature Date