



VitaFlex Orthodontia Expense Claim Form

Employee Data

| | |
|--|--|
| Company Name: | |
| Employee Name: | |
| Employee Social Security or ID Number: | |

Treatment Plan

| | |
|---|--------------------------------|
| Patient Name/Relationship: | |
| Provider Name: | |
| Banding Date: | Estimated Months of Treatment: |
| Total Amount Charged: | Up Front Fee: |
| Insurance Provider Name: | Insurance Benefit Amount: |
| I certify that the above referenced patient is under my care for orthodontia and that the dates, charges, and treatment information associated with the treatment plan provided above are accurate and correct. | |
| | |

Date

Provider Signature

Reimbursement Request

| Date of Payment | Amount Paid for Ortho Treatment | Debit Card?* |
|-----------------|---------------------------------|--------------------------|
| | \$ | <input type="checkbox"/> |

* Check box if the payment(s) noted above were made with your VitaFlex debit card.

Verification

To the best of my knowledge and belief, the statements in this medical expense claim form are complete and true. I certify these claims are for valid medical expenses provided on the dates indicated and that these expenses were incurred while I was actively participating in the VitaFlex Medical Reimbursement Plan, and that these expenses are incurred by an eligible participant under the plan (either myself as the eligible employee or an eligible dependent according to the guidelines of the plan). *These expenses have not been reimbursed under the VitaFlex plan previously nor have they been reimbursed under any other health plan. Additionally, I will not submit these expenses for reimbursement under any insurance plan or from any other source.* 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

Employee Signature

New Phone/Address (Complete Only if Needed)

| | |
|-----------------------------|-----------|
| New Preferred Phone Number: | () |
| New Email Address: | |
| New Home Address: | |