



# VitaFlex Over-the-Counter Item Clarification Claim Form

## Employee Data

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

## Patient Information (must be filled out by the employee)

Patient Name:	
Relationship to Employee:	

## Item Clarification (must be filled out by the provider or merchant)

Provider/Merchant:	
Over-the-Counter Item Description*:	
Amount Charged:	\$
Date of Purchase:	
Provider/Merchant Signature:	

*\*Please include the cash register receipt when submitting this completed form.*

## 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.

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Date

Employee Signature

## New Phone/Address (Complete Only if Needed)

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