Reimbursement Claim Form
Unreimbursed Medical Flexible Benefit Plan

Fax, Mail, or Email your claim form with substantiation:

Compensation Consultants, Ltd.
P.O. Box 720
Cloquet, MN 55720

Fax: 218-879-9684

Email: claims@ccflex.com

Employer Name:

Employee Name: Social Security Number:

Unreimbursed Medical Expense Claim				
Date Expense Incurred (mm/dd/yy)	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount
Attach appropriate substantiation and submit this claim form			**Total Medical Care Expense Claim**	

Read Carefully: The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned, and dependents by federal definition, was covered under the Employer's Cafeteria Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that he/she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state or city income tax on amounts paid from the Plan which relate to such expense.

Employee Signature:	**Date:**