125 Company	Your Flexible Benefits Organization

CLAIM FORM

Please submit this completed form along with all appropriate receipts by fax or mail to:

Please note you only need to send the information using one of the methods below.

Fax: (877) 303 – 0742	**Mail to: The 125Company, Inc.** **Flex Claims Group** **P.O. Box 2401** **Germantown, MD 20875**

For **FASTER PROCESSING**, you can submit claims online or by using your smartphone and upload the documentation. Try this first!

Employer Name:		
Employee Name:	**Social Security #:**	
Address:		
City:	**State:**	**Zip:**
Email:	**Phone #:**	

Dependent Care Claims - ***Please include provider name, address and Tax ID number. Attach a receipt from your provider or include the day-care provider's signature below*:**

Name of Dependent	From	To	Provider Name/Tax ID #	Amount
				$
				$
				$
Provider Signature:			**Total Claims:** $	0.00

Unreimbursed Medical Claims - *Please include either an Explanation of Benefits (EOB) or a detailed receipt from your provider or pharmacy that includes date of service, patient name, type of service or RX Name and amount.* ***Credit card receipts and canceled checks are not acceptable documentation.***

***Claims will be applied to your FSA Account unless indicated below that this claim is an HRA claim. Please check the box to indicate it is an HRA claim*:**

Date of Service	Name of Provider	Type of Service	HRA	Claimant	Amount
			☐		$
			☐		$
			☐		$
			☐		$
			☐		$
			☐		$
				Total Claims: $	0.00

I certify that these eligible expenses have been incurred by me, my spouse or eligible dependent and medical expenses are not for cosmetic purposes but for the treatment of an illness, injury, trauma, or medical condition. I certify that Dependent Day Care expenses were incurred in order for me and, if married, my spouse to work and are not for educational expenses to attend kindergarten or higher. I understand that "incurred" means the service has been provided that gave rise to the expense, regardless of when I am billed or charged for, or pay for the service. The expenses have not been reimbursed and I will not seek reimbursement elsewhere. I understand that any amounts reimbursed may not be claimed on my or my spouse's income tax returns. I have received and read the printed material regarding the reimbursement accounts and understand all of the provisions.

Signature:	**Date:**