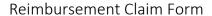
## MEDICAL FLEXIBLE SPENDING ACCOUNT



**EMPLOYEE NAME:** 



ADDRESS:		CELL PHONE: WORK PHONE:	
EMAIL:		EMPLOYER:	
LIVINIE. –			
<b>CERTIFICATION AN</b>	D AUTHORIZATION		
myself or an eligible de been previously reimbu addition, the expenses understand that if an e payment of all related i	pendent while I was a participant in thursed for these expenses and I will not for which reimbursement is sought xpense is determined to be ineligible, income taxes on amounts paid from the	mplete. I am requesting reimbursement plan. I have already received these put seek reimbursement of these expension to will not be claimed as tax deduction I am responsible for reimbursing the plan(s) which relate to such expension to the payment order determined	products and services and have not ses from any other plan or party. In ons on my personal tax return. I plan(s) for any such expense or for e. If I am covered under more than
Employee Signature:		Date:	
LINDEINADUDCED NA	EDICAL EVDENICES (MEDIELEV)		

SOCIAL SECURITY NO.

## UNREIMBURSED MEDICAL EXPENSES (MEDIFLEX)

Date Expense Incurred	Service Provider	Expense Description	n Person for Whom Expense Incurred	Net Amount
**Attach appropriat	te receipt(s) and submit w	ith this claim form.	Total Medical Expense Claim	

## **FAX OR EMAIL CLAIMS TO:**

3P Benefit Solutions Fax: 601-715-1855 claims@3pbenefits.com

\*Claims may also be filed and uploaded via Participant Portal via www.3pbenefits.com or by Apple/Android app 3P Benefits