

Flexible Spending Account Claim Form



Please print all information

Participant Information

Employer: _____ Daytime Phone #: () -
 Participant Name: _____ Social Security #: _____
 Address: _____ Check if new address
 Participant E-mail Address: _____ Check if new email address

Certification for Disbursement:

I certify that: (1) I have not knowingly made any false statements on this Claim Form; (2) the expenses listed above are for myself and my eligible dependents only; (3) I have not received any other payments for these expenses; and (4) the services for these expenses have been performed within the current plan year.

I understand that: (1) this plan is subject to regulations of the Internal Revenue Service; (2) I am responsible for consequences and/or penalties that may arise due to false statements, duplicate reimbursements, disallowed deductions and the like; and (3) I am responsible for any overpayments, and I am obligated to refund my Account and/or Plan Sponsor for any overpayments.

ACCEPTANCE OF FACSIMILE OR SCANNED SIGNATURES: Document signatures delivered by facsimile or email/pdf are valid and enforceable. Such facsimile or scanned signatures shall have the same force and effect as an original signature.

Participant Signature (Required) _____ Date _____

Unreimbursed Medical Expenses – You must attach an Explanation of Benefits or itemized receipts for each service

Debit Card Purchase		Patient Name/ Relationship	Dates of Service		Description of Service	Requested Amount
Yes	No		Start	End		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____	/ /	/ /	<input type="checkbox"/> Prescriptions <input type="checkbox"/> Copay/Deductible <input type="checkbox"/> Other Medical Services (lab, surgery, etc.) <input type="checkbox"/> Dental/Orthodontia <input type="checkbox"/> Vision/Hearing <input type="checkbox"/> Mileage <input type="checkbox"/> Other: _____	\$
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____	/ /	/ /	<input type="checkbox"/> Prescriptions <input type="checkbox"/> Copay/Deductible <input type="checkbox"/> Other Medical Services (lab, surgery, etc.) <input type="checkbox"/> Dental/Orthodontia <input type="checkbox"/> Vision/Hearing <input type="checkbox"/> Mileage <input type="checkbox"/> Other: _____	\$
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____	/ /	/ /	<input type="checkbox"/> Prescriptions <input type="checkbox"/> Copay/Deductible <input type="checkbox"/> Other Medical Services (lab, surgery, etc.) <input type="checkbox"/> Dental/Orthodontia <input type="checkbox"/> Vision/Hearing <input type="checkbox"/> Mileage <input type="checkbox"/> Other: _____	\$
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____	/ /	/ /	<input type="checkbox"/> Prescriptions <input type="checkbox"/> Copay/Deductible <input type="checkbox"/> Other Medical Services (lab, surgery, etc.) <input type="checkbox"/> Dental/Orthodontia <input type="checkbox"/> Vision/Hearing <input type="checkbox"/> Mileage <input type="checkbox"/> Other: _____	\$

Total Reimbursement Requested: \$

Dependent Care Expenses – You must attach itemized receipts for each service

Dependent Name/ Relationship	Dependent DOB	Provider Name	Provider Tax ID or SSN	Dates of Service	Requested Amount
				Start End	
<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____	/ /			/ / / /	\$
<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____	/ /			/ / / /	\$
<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____	/ /			/ / / /	\$

Total Reimbursement Requested: \$

How to Submit Claims



Online: www.member.varipro.com
Mobile App: Varipro Health Cloud app
Email: flex@varipro.com

FAX Varipro: 844-902-4564
Number of Pages: _____

Varipro
 5300 Patterson Ave SE, Suite 150
 Grand Rapids, MI 49512

Customer Service: 800-732-3412

For fastest results, file online at www.member.varipro.com or by using the Varipro Health Cloud app (available in both the Apple App and the Google Play Stores).