Flexible Spending Account Claim Form

Varipro
BENEFIT ADMINISTRATORS

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 Start	End	Description of Service	Requested Amount
☐ Yes	☐ No	____________ ☐ Spouse ☐ Child ☐ Other:____________	/ /	/ /	☐ Prescriptions ☐ Copay/Deductible ☐ Other Medical Services (lab, surgery, etc.) ☐ Dental/Orthodontia ☐ Vision/Hearing ☐ Mileage ☐ Other: ____________	$
☐ Yes	☐ No	____________ ☐ Spouse ☐ Child ☐ Other:____________	/ /	/ /	☐ Prescriptions ☐ Copay/Deductible ☐ Other Medical Services (lab, surgery, etc.) ☐ Dental/Orthodontia ☐ Vision/Hearing ☐ Mileage ☐ Other: ____________	$
☐ Yes	☐ No	____________ ☐ Spouse ☐ Child ☐ Other:____________	/ /	/ /	☐ Prescriptions ☐ Copay/Deductible ☐ Other Medical Services (lab, surgery, etc.) ☐ Dental/Orthodontia ☐ Vision/Hearing ☐ Mileage ☐ Other: ____________	$
☐ Yes	☐ No	____________ ☐ Spouse ☐ Child ☐ Other:____________	/ /	/ /	☐ Prescriptions ☐ Copay/Deductible ☐ Other Medical Services (lab, surgery, etc.) ☐ Dental/Orthodontia ☐ Vision/Hearing ☐ Mileage ☐ 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 Start	End	Requested Amount
____________ ☐ Spouse ☐ Child ☐ Other:____________	/ /			/ /	/ /	$
____________ ☐ Spouse ☐ Child ☐ Other:____________	/ /			/ /	/ /	$
____________ ☐ Spouse ☐ Child ☐ Other:____________	/ /			/ /	/ /	$
					Total Reimbursement Requested:	$

How to Submit Claims

Online: 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 member.varipro.com or by using the Varipro Health Cloud app (available in both the Apple App and the Google Play Stores).