***Keystone Flex Administrators, LLC***

Employer _____ **Claim For Reimbursement**

Name _____Social Security #(Last 4 Digits Only)XXX-XX-_____

## Dependent Care Expense Claims- ATTACH RECEIPTS***

| Name of Dependents | Period Covered From | To | Name, Address, and Taxpayer Identification Number of Provider of Service | Amount Incurred |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | **TOTAL DEPENDENT CARE EXPENSE CLAIM** | | |

## Unreimbursed Medical Expense Claims-ATTACH RECEIPTS***

| Date Incurred | Name of Service Provider | Expense Description | Person for Whom Expense Incurred | Net Amount |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | **TOTAL MEDICAL CARE EXPENSE CLAIM** | | |

**READ CAREFULLY**

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form and corresponding receipts were incurred during a period while the undersigned was covered under the Company'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 or she alone is fully responsible for the sufficiency and accuracy of all information relating to this claim and receipts which are 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's Signature Date

Please Mail Claims to: Keystone Flex Administrators, LLC
P.O. Box 5502
Edmond, OK 73083
(Phone: 405-285-1144)

_____

Day Time Phone Number

OR: ***Fax number***: 405-285-1763 (Toll Free Fax #1-855-259-1779

OR: ***Email:*** service@keystoneflex.com