Aflac™ Flex One® Request for Reimbursement Form

Instructions: Please print or type the information below. **FLEX ONE CLAIM FAX: 1.877.353.9256**

1. Sign and date form.
2. The Medical Care Total requested box **must be completed.**
3. Receipts attached must be clear and legible.
4. Allow 48 business hours to check status of reimbursement request.

Please maintain copies of all receipts for your records.

Employee Information ☐ Check here if address change

Participant's Social Security Number **Employer Name**

Last Name **First Name** **Middle Initial** **Participant's E-Mail Address**

Street Address **City** **State** **ZIP**

By submitting this claim form, I request reimbursement from my Flex One account as listed below. I agree to the Terms and Conditions outlined in my employer's Summary Plan Description. I certify and warrant to Aflac that these are eligible medical expenses that I or my dependents have incurred, are not cosmetic in nature and cannot be reimbursed from any other source. I will maintain copies of all documentation for my records.

Participant's Signature _____ **Date** _____

Medical Care FSA Claim Information

For **Medical Care expenses,** an Explanation of Benefits (EOB) from your insurance company or other receipt(s) must be submitted. ***The EOB and/or attached bills must contain the following items to be processed and approved:***

1. Patient Name 2. Service Provider 3. Description of Service 4. Date(s) Service Was Provided 5. Amount/Copay

List each receipt separately in the space(s) below. Use additional forms if necessary. A total must be indicated in the Total block below. Use the Provider Certification space below only if no receipt is attached. Do not indicate "see attached" in the spaces below.

FSA Card Receipt	Patient Name	Service Provider	Description of Service	Date Service Was Provided	Requested Amount
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TOTAL $ _____

Provider Certification

In lieu of receipts or EOB(s) the provider of the service can certify that the above listed medical care expenses have been incurred and only incurred by either the participant or his/her dependents. Any other expenses must have receipts or a separate completed form. Failure to complete all items will result in an invalid claim request.

Provider Name and Address _____ **City** _____ **State** _____ **ZIP** _____

Provider's Signature _____ **Date** _____

I certify that the Medical Care expenses listed above were incurred by the patient named above.

American Family Life Assurance Company of Columbus (Aflac)
Worldwide Headquarters • 1932 Wynnton Road • Columbus, Georgia 31999
1.877.353.9487 • aflac.com