MID AMERICAN GROUP
THE LEADING EDGE™

# SECTION 125 HEALTH CARE FSA REIMBURSEMENT CLAIM FORM

***How to file a claim:***

Reimbursement can only be made when one of the following IRS-required items is included with this claim form.

1) For out-of-pocket insurance expenses (for example deductibles, co-insurance) copies of the Explanation of Benefits (EOB) or worksheet from your Health/Dental Plans
2) For other items considered reimbursable by the IRS, copies of receipts obtained from provider of services.
   When the above item(s) are attached to the claim form, please mail, fax, or e-mail to:
   **By Mail: Mid American Group, Inc., P.O. Box 482, Westmont, IL 60559**
   **By Fax: 630-789-9421 By E-Mail: flexclaims@midamgroup.com**

| YOUR INFORMATION: | |
|---|---|
| YOUR EMPLOYER: | |
| YOUR NAME: | |
| YOUR ADDRESS: | |
| | |
| YOUR SSN: | - - |

| Provider: | Type of Service: | Date(s) of Service: | Cost of Expense: |
|---|---|---|---|
| | | | $ |
| | | | $ |
| | | | $ |
| | | | $ |
| | | | $ |
| | | | $ |
| | | | $ |
| | | | $ |
| | | | $ |
| | | | $ |
| | | TOTAL: | $ |

**PAYMENT AUTHORIZATION**

I request payment from my Reimbursement Account for the expenses itemized and attached, and understand that the expenses reimbursed cannot be claimed on my personal income tax return. I certify that all of these expenses have not and will not be paid by any other plan or program of any employer or other person.

| Employee Signature**: | Date: / / |
|---|---|

** By typing your name in the above box you certify the above statement is true.