

SECTION 125 INSURANCE PREMIUM FSA REIMBURSEMENT CLAIM FORM

How to file a claim:

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

- 1) The bill or proof of payment from the insurance company for the premium.

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:	- -

Insurance Company:	Type of Insurance (i.e. COBRA, Individual):	Date(s) of coverage:	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: / /
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** By typing your name in the above box you certify the above statement is true.