



Please type or print all information

**COMPANY NAME:**

**ONLY USE THIS FORM IF YOU HAVE ONE OF THESE CARDS**

Social Security Number: (for security purposes please provide at least the last 4 digits of you ss#)

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Employee Last Name:

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Employee First Name:

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**MEDICAL EXPENSES**

- Documentation for each request will need to show date of service, description of service provided and charge for service as well as the providers name and address.
- Please itemize your expenses to help assure proper processing. If you have more expenses than this form allows please attach a separate form. If you do not itemize your expenses we will process your claim based on the documentation received
- Mail claims to: 9246 Portage Industrial Dr, Portage MI 49024; Fax: 800-391-6562 or Email to [claims@basiconline.com](mailto:claims@basiconline.com)
- For questions call 800-444-1922 ext 1 or 269-327-1922 ext 1

| Flex debit card used for this expense | Date of service | Provider name or name of store | Amount |
|---------------------------------------|-----------------|--------------------------------|--------|
| YES NO                                |                 |                                |        |
| YES NO                                |                 |                                |        |
| YES NO                                |                 |                                |        |
| YES NO                                |                 |                                |        |
| YES NO                                |                 |                                |        |

**DAY CARE EXPENSES (dependent care account)**

• Please have your day care provider sign this form on the line below or provide a receipt for the services

| Flex debit card used for this expense | Dates of service | Day care provider name | Amount |
|---------------------------------------|------------------|------------------------|--------|
| YES NO                                |                  |                        |        |
| YES NO                                |                  |                        |        |
| YES NO                                |                  |                        |        |
| YES NO                                |                  |                        |        |

SIGNATURE OF DAY CARE PROVIDER: