BASIC FLEX

Please type or print all information.

COMPANY NAME:

Last 4 digits of Social Security Number:

Employee Last Name:

Employee First Name:

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
- For questions please call 800-444-1922 ext 1 or 269-327-1922 ext 1

Date of service	Provider name or name of store	Amount

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

Dates of service	Day care provider name	Amount

SIGNATURE OF DAY CARE PROVIDER: _____