SECURITY BENEFIT®

Questions? Call our National Service Center at 1-800-888-2461.

Security Flex 125 Program®
Medical/Dependent Care
Reimbursement Program Claim Form

Instructions

Use this form to request medical expense or dependent care reimbursement. Complete the entire form. Please type or print

1. Complete the worksheet on the back of this form to itemize expenses and attach legible copies of receipts.
2. Must sign **Section 3**.
3. Completion of **Section 4** is optional, but will speed the processing of your claim.
4. This completed form and all required attachments should be mailed to:
   Security Benefit
   P.O. Box 750600
   Topeka, KS 66675-0600

1. Provide Personal Information

Employer Name _____

Name of Employee _____ ____ _____
First MI Last

Mailing Address _____ _____ _____ _____
Street Address City State ZIP Code

Social Security Number _____

Daytime Phone Number _____ Home Phone Number _____

2. Select Type of Claim

Please select one:

❍ **Dependent Care Reimbursement**
Requested Amount: $ _____

❍ **Medical Expense Reimbursement**
Requested Amount: $ _____

❑ Requesting **check** payment option.

❑ Please provide your bank information below if you wish to have payments from Security Benefit made by direct deposit to your bank account. If any information is missing your request may be delayed. You may also attach a void check to ensure necessary information is provided. Receipt by said bank of such credit entries shall be deemed receipt by you.

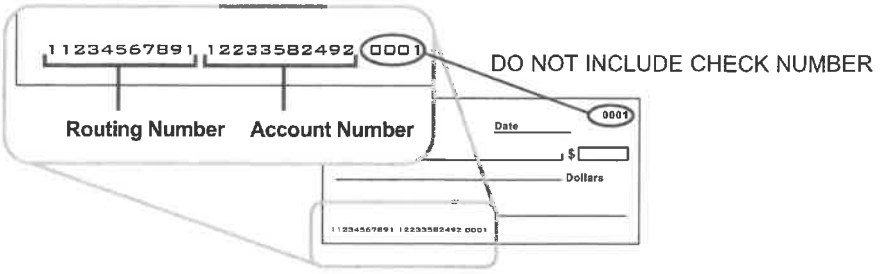
Bank Account Type (please check one): ❍ Checking ❍ Savings

Bank Name _____

Name on Bank Account _____

Bank Routing Number _____

Bank Account Number (Do not include the check number) _____



3. Provide Signatures

I agree:

- That this claim represents qualifying medical or dependent care expenses not covered/reimbursed by insurance.
- My signature below confirms my understanding and agreement with this requirement.
- I further understand that any claim that does not meet these requirements may result in this payment being considered a taxable payment by the IRS.
- I understand that the direct deposit arrangement will continue until Security Benefit receives written notification from me stating otherwise.
- This is to certify that I have incurred expenses that qualify for reimbursement under my employer's Security Benefit Medical/Dependent Care Reimbursement Program. None of these expenses have previously been submitted.
- I certify that these expenses will not be paid or reimbursed by any insurance company or from any other source or I may be subject to IRS fines and/or penalties of perjury. I hereby request reimbursement for these expenses to the extent allowable. I understand that at the end of the plan year all unpaid claims (even if less than $25.00) will be reimbursed in full and that any remaining fund balances at the end of the plan year will be forfeited to my employer.

X_____ _____

Signature of Employee — Date (mm/dd/yyyy)

4. Provide Summary of Itemized Bills

For each expense that you are submitting for reimbursement, you must provide all information below.

Name of Physician, Hospital Pharmacy or other Provider of Service	Description of service, if drug include name, days supply and quantity	Patient Name	Date of Service	Amount of Charge

Eligible expenses generally include health care expenses that are not covered, or only partly covered, by your health plans or, if you're married, by your spouse's health plans. Some of the expenses you can claim are:

Deductibles and co-payments under medical, dental, and prescription drug plans; Expenses for medical services or supplies not covered by your plans (for example, many plans do not cover routine physical or well-child care); Vision care expenses, including eye exams, eyeglasses, as prescribed by your doctor, and materials and equipment needed for using the eyeglasses such as eyeglass cleaner, contact lenses and contact lens supplies; Lasik, Laser eye surgery and Radial keratotomy; Hearing care expenses, including hearing exams and hearing aids; Expenses in excess of medical or dental plan limits (for example, orthodontic expenses greater than the limit set by your dental plan); Transportation expenses related to medical care; Nursing services not covered by your medical plan; Wheelchairs and crutches; Capital expenses for a personal residence to accommodate a disabled condition less the increase in your property value; Pregnancy test (over the counter); Certain over the counter drugs (with a prescription); Over the counter reading glasses when accompanied by a prescription; Smoking cessation program; Weight loss program when it is prescribed by your doctor for a specific diagnosis.

Expenses that are not Eligible

Most cosmetic surgery; Health club dues; Electrolysis; Over the counter vitamins, even when prescribed by a physician; Dietary supplements; Teeth whitening products; Insurance Premiums of any nature.

For expenses that are not listed you can refer to IRS Section 213 for more complete information or contact Security Benefit at 1-800-888-2461.

Mail to: Security Benefit • PO Box 750600 • Topeka, KS 66675-0600 or
Fax to: 1-866-477-6526
Visit us online at www.securityflex.com • E-mail: ebdept@securitybenefit.com