FLEXIBLE BENEFIT PLAN – MEDICAL/DENTAL/VISION CLAIM FORM

NAME (as it appears on payroll) _____ **SOCIAL SECURITY NUMBER** _____

COMPLETE FOR MEDICAL EXPENSES COVERED BY INSURANCE SHOWN ON YOUR EXPLANATION OF BENEFITS
(Amounts that are Patient's Responsibility after Insurance has paid their part)

SERVICE FROM	SERVICE TO	PATIENT'S FULL NAME	LIST MEDICAL CARE OR CLAIM EOB NUMBER	CHARGES

COMPLETE FOR QUALIFIED EXPENSES NOT COVERED BY INSURANCE - ATTACH RECEIPTS
(Dental, Vision, and Over-the-Counter)

SERVICE FROM	SERVICE TO	PATIENT'S FULL NAME	COMPANY OR PROVIDER	DESCRIPTION OF SERVICE	CHARGES

I certify that expenses submitted under this claim:

1. Are medical care for me, my spouse, or my dependents
2. Have not been previously submitted, or otherwise reimbursed

_____ _____
Employee Signature **Date**

Please send to: Werntz & Associates, Inc.
Cafeteria Department
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Shreveport, LA 71135-5606
Fax: 318-798-3206, E-mail: cafeteria@werntz.com