MAIL TO:
PayFlex Systems USA, Inc.
P.O. Box 3039
Omaha, NE 68103-3039
PH: 800-284-4885

Wellness Reimbursement Account (WRA) CLAIM FORM

FAX TO:
PayFlex Systems USA, Inc.
(402) 231-4310
(No Cover Page Required)
Page 1 of _____

WAIT! Did you know that you can file this claim online? Go to www.mypayflex.com and select *Express Claims.*
You can access your account balance, view a listing of eligible expenses and frequently asked questions all in one place!

Employee Name _____ **Member Number** _____
(SSN)

Employer Name _____El Paso County_____

Note: To make an address change, please contact your employer's HR/Benefits department. For security purposes, we cannot accept address changes directly.

Wellness Account Claims

Wellness accounts are unique to your employer. As a result, your specific plan will only cover the expense types listed below. If you are also enrolled in a Flexible Spending Account (FSA), funds must be exhausted in this account before you can submit a Wellness Reimbursement Account claim. You can only receive reimbursement for the same expense from one account, not both.

Covered by insurance – All expenses must be submitted to CIGNA before submitting for reimbursement. This claim form should only be used for expenses applied to your medical deductible, coinsurance and copayments (co-pays for prescriptions are not eligible). When you receive the Explanation of Benefits (EOB) from CIGNA, submit a copy to PayFlex along with this completed claim form.

Date of Service	Type of Service (Medical Deductibles, Co-insurance and Co-Pays only)	Amount Requested	Date of Service	Type of Service (Medical Deductibles, Co-insurance and Co-Pays only)	Amount Requested
			Total		**$**

I certify that these eligible expenses have been incurred by me, my spouse or eligible dependent and medical expenses are not for cosmetic purposes but for the treatment of an illness, injury, trauma, or medical condition. I understand that "incurred" means the service has been provided that gave rise to the expense, regardless of when I am billed or charged for, or pay for the service. The expenses have not been reimbursed and I will not seek reimbursement elsewhere. I understand that any amounts reimbursed may not be claimed on my or my spouse's income tax returns. I have received and read the printed material regarding the WRA plan and understand all of the provisions.

Employee Signature _____ **Date** _____

****Make copies for yourself, since these documents will not be returned. If you fax your claim, keep the original.****

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