

# CLAIM FORM

## Medical Flexible Spending Account

EMPLOYER Name: \_\_\_\_\_

EMPLOYEE Social Security Number: \_\_\_\_\_

EMPLOYEE Name: \_\_\_\_\_

Street Address/PO Box: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Claim(s): \_\_\_\_\_ Amount of claim(s): \_\_\_\_\_  
\*\*\*List all dates\*\*\* \*\*\*Put total of ALL claims\*\*\*

Please Note:

### Receipts must be attached for reimbursement.

If this is for medical spending accounts you must have the EOB to be reimbursed for the remaining of medical, dental or vision. If you do not have insurance for the claim you are submitting, than a receipt from the provider will work.

Please send to: Eagles, Benefits By Design (Eagles)  
2336 SE Ocean Blvd., Suite 301  
Stuart, FL 34996  
Fax 1-772-334-7059

If you have questions, please call 1-800-726-5603.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_