INSURANCE COORDINATORS OF MONTANA, INC.
FLEXCONNECT

EMPLOYER NAME_____

INSURANCE PREMIUM EXPENSE CLAIM FORM

Social Security No.:_____

Participant's Name:_____
Last First Middle

The undersigned participant in the Plan requests reimbursement in the amounts shown below for insurance premiums.

INSURANCE PREMIUM EXPENSES

Period Covered	Name of Insurance	Insurance Type (Health/Disability)	Person(s) Covered	Paid to Spouse's Employer	Net Amount
				Yes No	$
				Yes No	$
				Yes No	$

Total amount of insurance premium expenses claimed. $

Policies should be pre-approved by Employer to guarantee their eligibility under Plan provisions.

NOTE: *Federal law requires that you submit a written statement such as the premium statement from the insurance provider. The premium statement should reflect the period of coverage, the premium amount and verification that the premium was not paid to spouse's employer. Also, you will not be entitled to claim this expense as a tax deduction.*

READ CAREFULLY: *The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form, were incurred during a period while the undersigned was covered under the Plan with respect to such expenses and that such expenses have not been reimbursed, or are not reimbursable, under any other source. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid from the Plan which relate to such expense. The undersigned further understands that no tax deduction is permitted for amounts for which reimbursement is made.*

_____ Date_____
Employee's Signature

Adequately documented claims will be processed within three working days.

Claims may be sent to:	FlexConnect, P.O. Box 2019, Helena, MT 59624
Contact us at:	Phone: (406) 442-3539 or (866) 640-3539 - Fax: (406) 495-3669
	Visit our Website at *www.inusurancecoordinators.com*