COMMUNITY CARE MANAGEMENT SRVCS, INC.
MAX 105 PLAN CLAIM FORM

Flexible Benefit Group
1575 Redbud Blvd., Suite 100
McKinney, TX 75069

Voice: (972) 991-3539 or (800) 249-9970 Fax: (972) 991-5155 Email:fbgfax@flexiblebenefitgroup.com

Employee's Name Soc. Sec. #

Street City State Zip

MEDICAL REIMBURSEMENT ACCOUNT FOR MAX 105

Eligible expenses are those which are defined in the Max-105 plan documents. I hereby file claim for the eligible expenses noted below. I certify that each expense was incurred on the date and for the person and reason noted and is not covered by other insurance. Attached are EOBs as evidence of my having incurred these expenses during the plan year. I understand that my employer has the right to verify these expenses.

Date Incurred	Person Treated	Nature of Expense	Amount of Expense
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
		Total Max 105 Expenses Claimed	$

Signature: Date:

Please Note: Signature of employee is required for payment from Max 105 Account.