CRIDER INSURANCE SERVICES, INC.
THIRD PARTY ADMINISTRATORS
7755 Bellaire Drive South Suite C Fort Worth, TX 76132
Mailing address: P.O. Box 34507 Fort Worth, TX 76132
817-735-8304 817-735-8301 (FAX) 1-800-466-2324 (TOLL FREE) email: criderins@aol.com

How to file a Health Care Reimbursement Claim

As a participant in your employer's Flexible Spending Account for health care, you have three options for filing a claim with Crider Insurance Services, Inc. (CIS).

Each option requires completion of the attached Health Care Expense Claim Form and the attachment of receipts from your health care providers (physicians, dentists, hospitals, or prescription drugs).

OPTION ONE
You may mail the forms and receipts to our office at the address shown above.

OPTION TWO
You may fax the form and receipts to our dedicated fax line 817-735-8301

OPTION THREE
You may scan the form and receipts and email these to our email address: criderins@aol.com

Processing your Claim

We process claims daily. Our goal is to pay the claim the same day it is received. However, there may times due to holidays, time of day we receive your claim, or your employer has not remitted payments, that it may take up to 3 business days + mail days to complete processing your claim.

DIRECT DEPOSIT
If you want us to direct deposit (ACH) your claim payment to your bank account, please complete the direct deposit form attached and fax or email to us along with a voided check. Call us if you have question about this process.

CRIDER INSURANCE SERVICES

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(800) 466-2324 * (817) 735-8304 * Fax (817) 735-8301

HEALTH CARE EXPENSE CLAIM FORM

Social Security No:____

Participant's Name:____

To: Crider Insurance Services – Plan Administrator

The undersigned participant in the plan requests reimbursement (attach itemized bills, receipts, and invoices for all expenses claimed) in the amounts below: (If additional space is needed, please use the back of this form.)

MEDICAL CARE EXPENSE

Date Incurred	Name of Service Provider	Describe Expense	Person for Whom Expense Incurred	Net Amount
				$
				$
				$
				$

Total expenses from reverse side: $___________

Total amount of medical expense: $___________

PLEASE 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 employer's Cafeteria Plan with respect to such expenses and the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. 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 prior expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

____ ________________________________

Employee's Signature Date

For Plan Administrator Use:

Payment Authorized:____________ Check No.______________

Amount $______________________ Date:__________________

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DIRECT DEPOSIT INSTRUCTIONS
FLEXIBLE SPENDING ACCOUNTS

Want a way to get your money faster and with less hassle? Then sign up for direct deposit.
IT'S SIMPLE TO DO!!!!

Procedure to start direct deposit program (you may fax your information):

1. Regular checking account
   a) Send us your **VOIDED CHECK** with social security number, address, telephone number and email address.

2. Savings account
   a) Bank will have a form they will complete for you to send us (include your social security number and telephone number).

3. Federal Credit Union
   a) Credit union will have a form they will complete. You MUST note whether account is checking or savings (include your social security number and your agent number).

THAT'S IT!! THIS IS ALL WE NEED IN ORDER TO SET YOU UP ON DIRECT DEPOSIT. NO MORE WAITING FOR THE CHECK IN THE MAIL!

If you have any questions, please call Andy Crider at 800-466-2324.

____
Signature

____
Address

____
City, State, Zip

Enclosed
Voided check ______

____
Social Security Number

____
Phone number

____
Email address