Keystone Flex Administrators, LLC

Otoe-Missouria Tribe Extraordinary Assistance Claim for Reimbursement form

Name _____Social Security #(Last 4 Digits Only)XXX-XX-_____

Medical/Dental/Vision Expense Claims-ATTACH RECEIPTS***

Date Incurred	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount
		TOTAL OF EXPENSE CLAIM :		

****READ CAREFULLY****

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form and corresponding receipts were incurred during a period while the undersigned was covered under the Otoe-Missouria Tribe's Extraordinary Assistance Program with respect to such expenses. The undersigned fully understands that he or she alone is fully responsible for the sufficiency and accuracy of all information relating to this claim and receipts which are provided by the undersigned.

_____ _____

Employee's Signature Date

Please Mail Claims to: Keystone Flex Administrators, LLC
P.O. Box 5502
Edmond, OK 73083
(Phone: 405-285-1144)

_____

Day Time Phone Number

OR: ***Fax number***: 405-285-1763 (Toll Free Fax #1-855-259-1779
OR: ***Email:*** awheeler@keystoneflex.com