Employer: ______________________

Employee: ______________________

Member ID (which may be your SSN): ______________________

Phone: ______________________

Email: ______________________

MyAmeriflex Card Transaction to Refund

Account Type: ______________________

Transaction Date: ______________________

Provider Name: ______________________

Amount of Transaction: ______________________

Amount of Enclosed Check: ______________________

Check Number: ______________________

Mail Refund to:
Ameriflex Claims Department
PO Box 269009 Plano, TX 75026

Please complete this form in its entirety.
Incomplete forms will cause a significant delay in processing.