54 Westchester Drive
Suite 20
Austintown, Ohio 44515
Phone: 330-953-2307
Fax: 877-402-1185

HEALTH REIMBURSEMENT ARRANGEMENT CLAIM FORM

PLAN YEAR**:**_____ EMPLOYER:_____

EMPLOYEE NAME:_____ SS#_____

PLEASE BE SURE TO ATTACH COPIES OF ALL RECEIPTS, PHYSICIAN BILLINGS OR EOB'S NECESSARY TO PROCESS YOUR REIMBURSEMENT.

REIMBURSEMENT REQUEST (In Network Medical Deductible)

Date Incurred	Provider Name	Patient	Expense Description	Amount

TOTAL REIMBURSEMENT REQUESTED: $_____

Please read the following:

I certify that all expenses for which I am requesting a reimbursement under the Plan were incurred by me or an eligible family member within the Plan Year above. I also certify that these expenses have been paid by me and that in the case of qualifying medical expenses, they have not been reimbursed or are not reimbursable under any other medical plan. I understand and I will not use qualifying medical expenses reimbursed through my medical reimbursement account as deductions when filling my Federal Income Tax return.

I understand that I am responsible for the accuracy of all information relating to medical claims which are provided by me, and that unless an expense is a qualifying expense under the Plan, I will be responsible for payment of all related taxes and unemployment taxes on amounts paid from the plan which related to such expense.

Signature:_____ Date:_____