

**Unreimbursed Medical
Reimbursement Claim Form**

To expedite your claim:
Provide all appropriate information.
Review the Total Medical Care Expense

Employer: _____
 Employee Name: _____ Social Security Number: _____
 Phone: _____ E-mail: _____

Unreimbursed Medical Expense Claims

Date Expense Incurred	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount
Attach appropriate receipt(s) and submit with this claim form.			Total Medical Care Expense Claim	\$

Read Carefully: The undersigned participant in the Plan certifies that all services for which reimbursement of payment is claimed by submission of this form were provided during a period while the undersigned was covered under the Company's Cafeteria Plan with respect to such expenses and that 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 proper 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

Send Completed Form with Receipts Attached to:
Employee Benefit Concepts, Inc.
 28800 Orchard Lake Road, Suite 210
 Farmington Hills, MI 48334
claims@employeebenefitconcepts.com
 Fax: (248) 855-2454 Phone: (248) 855-8040