

Reimbursement Claim Form  
Health Care

Total # of Pages?  
\_\_\_\_\_

Employer: \_\_\_\_\_

Participant's Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Participant's Address: \_\_\_\_\_

Daytime Telephone #: \_\_\_\_\_ Email address: \_\_\_\_\_

**Please attach receipts, bill or invoices.**

NOTE: Federal law requires that you submit a written statement (such as an itemized statement from your benefit provider) as well as proof that the claim is not being reimbursed by an insurance company. Also, you will not be entitled to claim this expense as a tax deduction.

Entire form must be completed. Please use separate sheet if more lines are needed.

All Claims must be listed out individually in full.

**MEDICAL CARE EXPENSE**

Date of Service	Name of Service Provider	Describe Expense	Person for whom Expense Incurred	Net Amount
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____

**Total amount of medical expenses** (including amounts from additional pages) \$ \_\_\_\_\_

**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 Plan with respect to such expenses. 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 the payment of all related taxes including federal, state or city income tax on amounts paid from the Plan which relate to such expense. The undersigned further understands that no medical expense tax deduction is permitted for amounts for which reimbursement is made.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Send Claims to:  
American Benefit Services  
P.O. Box 1635  
Irmo, SC 29063  
Fax# 803-407-1649**

