Health Care Benefits

1. Complete the entire form, listing each expense. Remember to SIGN and DATE the form.
2. Staple a copy of your Explanation of Benefits (EOB) from your insurance company to this form, **OR** attach a receipt from your provider and showing date of service, service performed and cost.

EMPLOYEE INFORMATION

Employer Name _____ Social Security No. _____

Employee Name _____ Daytime Phone #: ( ) –

Street _____

City _____ State _____ Zip _____

Date of Service	Family Member	Provider Name and Description of Service	Total Expense	$ Paid By Insurance *	Requested Reimbursement

*Expenses covered by your health insurance carrier will require submission of your Explanation of Benefits (EOB). The EOB outlines the charges paid by your insurance plan and the portion for which you are responsible to pay. To obtain an EOB, submit the expense to your group health insurance carrier.

I certify that I am claiming reimbursement only for eligible expenses incurred during the applicable plan year for qualifying individuals. These expenses **have not** been reimbursed by any other source and will not be claimed as an income tax deduction. The attached receipts and/or EOB's support all expenses for which I am claiming reimbursement.

Employee Signature: _____ **Date:** _____