HEALTH CARE SPENDING ACCOUNT
Claim For Reimbursement

Name of Employer		
Employee Name		Soc. Sec. Number - -
Employee Address	Street	City
State		Zip

HEALTH CARE EXPENSES

NAME OF PERSON FOR WHOM HEALTH CARE SERVICE WAS PROVIDED	DATES OF SERVICE		PROVIDER OF SERVICE	(A) TOTAL CHARGE	(B) AMOUNT PAID BY OTHER SOURCES	(A-B) AMOUNT TO BE REIMBURSED
	From	To				
			TOTALS			

CERTIFICATION

I certify that the expenses for which I am requesting reimbursement **meet all of** the conditions listed below:

They were incurred for services or supplies received by me or my eligible **dependents** under the plan.

They were for services or supplies furnished while I was a participant in the **Plan.**

I **have** not been reimbursed for these expenses and they are not reimbursable **from any other** health plan.

I **understand** that **reimbursement** of these expenses can be requested and **made only after I have** collected all benefit payments available from all plans under which my **eligible** dependents and I are covered.

I **further certify that I have not deducted** nor will deduct on my **individual income tax** return any of the expenses reimbursed through my Health Care Spending Account

I understand that reimbursement **Will be made in accordance with the provisions of the** plan in which I participate. **I accept responsibility for the** proper treatment **of benefits paid** under **this** plan with respect to **eligibility, income tax reporting** and liability.

EMPLOYEE SIGNATURE	DATE

COMPLETION OF CLAIM FORM

- Complete all information on **the** claim form for each amount claimed **for reimbursement.**
- Make sure the claim does not include items for more than one plan year.
- You must sign and date claim form.
- A copy **of a bill or other written** statement **from** the provider of service is acceptable **only** when NO other insurance is applicable.
- **If** Insurance Is applicable, **a** statement from all medical/dental Insurance carriers **showing deductible** and copayments is required.

MAIL COMPLETED **FORM TO:**

FITZHARRIS & COMPANY, INC.

P0 **BOX** 9182

FARMINGDALE. NY **11735-9182**

(516) 777-2244 **1-800-321-1336**

FAX (516) 777-5777/78