Premium Reimbursement Account Claim Form

Your Name (Last, First, MI)	Social Security No. or EID	Your Employer Name

Address	City	State	Zip Code

Insurance Expenses

Please submit a detailed billing statement from your insurance carrier to support your expense is valid. Paid receipts are not sufficient documentation.

Coverage Period	Insurance Provider/Carrier	Amount Requested
		$
		$
		$
		$
		$
		$
	Total	**$**

I certify that all expenses for which reimbursement or payment is claimed by submission of this form were incurred by me, an eligible spouse, or an eligible dependent during a period while I was covered under my employer's Plan and that the expenses have not been reimbursed and reimbursement will not be sought from any other source. I understand that I am fully responsible for the accuracy of all information relating to this claim, and that unless an expense for which reimbursement is claimed is a proper expense under the Plan, I may be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan which relate to such expense. A claim will only be processed with a completed and signed claim form and correct documentation.

✔ **Employee Signature** _____ **Date** _____