

MEDICAL CARE EXPENSE CLAIM FORM

Employee Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Plan Year: \_\_\_\_\_ through \_\_\_\_\_

The undersigned participant in the plan requests reimbursement in the amounts shown below: (If additional space is needed please use an additional form.)

NOTE: Federal law requires that you submit a written statement (such as an itemized bill from the 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.

MEDICAL CARE EXPENSE

Date Incurred	Name of Service Provider	Describe Expense	Person for Whom Expense Incurred	Net Amount
XXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	<b>TOTAL</b>	<b>\$</b>

**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 the period while the undersigned was covered under the City of Traverse City Flexible Spending Plan with respect to such expenses and that such 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 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.

If, for any reason, my participation in the City of Traverse City Flexible Spending Plan terminates at a time when I have received Medical Expense Reimbursements in an amount greater than what I have paid (through salary reduction or otherwise), then I shall be obligated to pay the City of Traverse City the difference between the amount I have received and the amount I have paid into my account(s). Upon termination of employment such amount may be deducted from my final paycheck.

Employee's signature: \_\_\_\_\_ Date: \_\_\_\_\_