Insert Employer Name

REQUEST FOR REIMBURSEMENT
HEALTH CARE

Please print or type.

Last, First, Middle Initial — 000-00-0000

Employee (Last Name, First Name, Middle Initial) — Social Security Number

Street Address

Employee Address

City, State, Zip

City, State, Zip

(000) 000-0000

Daytime Phone

Please be sure to staple documentation to the back of this claim form. Acceptable documentation is 1) Explanation of Benefits (EOB) from the insurance company; 2) statement or bill from the health care provider that shows date of service and your financial responsibility; or 3) for contact lens supplies and co-payments only, a receipt.

To be eligible for reimbursement, a health care expense must 1) be for you, your legal spouse, or dependent as defined by the IRS; 2) be for services performed during the plan year; and 3) not be covered by health insurance (i.e. an out-of-pocket expense).

INSTRUCTIONS

Fill in the information below for health care expenses incurred by you or your eligible dependent for which you request payment. Each expense item must be accompanied by a receipt or bill or copy of your receipt or bill stating the DATE OF SERVICE. *Do not attach receipts or bills which do not identify your expense as a health care expense.* NOTE: Expenses covered under a medical, dental, vision or hearing plan must be submitted under that plan first. ATTACH A COPY OF THE EXPLANATION OF BENEFITS YOU RECEIVED FROM THE INSURER OR A CO-PAY RECEIPT. Please keep a copy for your records.

Date Expense Incurred	Name & Relationship of Person Incurring Expense	Description of Expense	Total Expense	Paid by Insurance	Your Unreimbursed Expense
			$	$	$
			$	$	$
			$	$	$
			$	$	$
			$	$	$
			$	$	$
			$	$	$
			$	$	$
			$	$	$
				TOTAL:	$ 0.00

CERTIFICATION BY THE PLAN PARTICIPANT

I certify that I am responsible for the validity of this claim and that the expenses listed are not eligible for further reimbursement under any other health plan. I further certify that I have not and will not claim the listed expenses as an income tax deduction.

Signature of Participant _____ Date _____

SEND COMPLETED CLAIM FORM TO OUR ADDRESS:

Benefit Administration Company LLC
P.O. Box 550
Seattle, WA 98111-0550
(206) 625-1800
(206) 682-8016 FAX
If faxing claim do not mail original.

For additional copies of this form or to view your account, please visit our website, www.baclink.com.