

**HEALTH CARE SPENDING ACCOUNT
CLAIM FOR REIMBURSEMENT**

Employer Name:	
Employee Name:	Social Sec. No.
Street Address:	City:
State:	Zip Code:

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 by 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 the 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.

COMPLETE & RETURN TO:

FITZHARRIS & COMPANY, INC.

PO BOX 9182
 FARMINGDALE, N.Y. 11735
 (516) 777-2244 - FAX: (516) 777-5777 / 78