SCHOOL DISTRICT OF THE CITY OF ADRIAN

MEDICAL EXPENSE REIMBURSEMENT PLAN

REQUEST FOR REIMBURSEMENT FORM

Participant's Name:_____ Soc. Sec. #_____

Date of Service	Name of Individual for whom expense incurred	Relationship	Physician or Provider	Amount of Expense

Total amount requested: $_____

I represent that the information provided above and attached hereto is true and accurate, and that I incurred the expenses listed above on behalf of myself and/or a Dependent of mine. No part of this expense is reimbursable to me or my spouse or Dependent under any insurance contract or under any other plan of this or any other employer of myself, my spouse, or my Dependent. I agree to provide such additional information as the Plan Administrator may require.

Participant's signature:_____ Date:_____

Date received by Plan Administrator:_____ Initials:_____

ATTACH COPY OF ORIGINAL INVOICES/RECEIPTS.

(See description of eligible medical expenses on reverse side)