Medical Health Reimbursement Account Claim Form

Part A:
PERSONAL INFORMATION

Last Name | First Name | Phone Number

Member ID Number | Name of Employer

Part B:
REIMBURSEMENT INFORMATION

Service Date from | Service Date to | Reimbursement Requested $.

Provider Name | Type of Service*

Service Date from | Service Date to | Reimbursement Requested $.

Provider Name | Type of Service*

Service Date from | Service Date to | Reimbursement Requested $.

Provider Name | Type of Service*

Total Reimbursement .

Part C:
Attach **COPY** of itemized receipts.

* Be specific with the type of service

I certify that the expenses for which I am requesting reimbursement meet all the conditions listed below:

- They were incurred for services or supplies received by my eligible dependents or me under the plan.
- They were for services or supplies furnished on or after the effective date of my employee reimbursement account.
- I have not been reimbursed for these expenses in any other way or from any other source.

I understand that reimbursement of these expenses should 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 I deduct on my individual tax return any of the expenses reimbursed through my health care reimbursement account. I understand that reimbursement will be made in accordance with the provisions of the plan. I accept sole responsibility for the proper treatment of benefits paid under this plan with respect to eligibility, income tax reporting and liability. Wausau Benefits shall not be liable for any penalties or damages as a result of an inappropriate claim filed by me. I will retain a copy of this form and all original receipts for my records.

Employee Signature | **Date**

FAX TO: 877-293-4911
SEND TO: UMR - PO Box 30541, Salt Lake City UT 84130-0541
INQUIRIES: www.umr.com - 1-800-826-9781

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