STEWART'S SHOPS CORP.
2015 MEDICAL REIMBURSEMENT CLAIM VOUCHER

Please review the following claims instructions to insure that your claim will be processed properly.

1. Please remember: this form may only be used for **submissions for the 2015 plan year**
2. All reimbursement requests for 2015 must be received **no later than March 1, 2016**
3. Complete this form and submit with your supporting documents.
4. Supporting documents can be your bills, receipts or explanation of benefits from your insurance carrier; all documents should include date of service, patient's name and services rendered. Please be sure to submit proof of payment including receipts and/or cancelled checks.
5. Submit all documents to Christina Cicardi x 3340 in the Personnel Department for reimbursement.
6. Make a photocopy of all documents for your records.

_____ _____

Name of Employee (Last, First, Initial) Social Security Number or Employee Number

UNINSURED MEDICAL OR DENTAL EXPENSES

	Date Incurred	Name	Relationship	Description	Amount
1.	_____	_____	☐ Self ☐ Spouse ☐ Dependent	☐ Prescription ☐ Medical ☐ Vision ☐ Dental	_____
2.	_____	_____	☐ Self ☐ Spouse ☐ Dependent	☐ Prescription ☐ Medical ☐ Vision ☐ Dental	_____
3.	_____	_____	☐ Self ☐ Spouse ☐ Dependent	☐ Prescription ☐ Medical ☐ Vision ☐ Dental	_____
4.	_____	_____	☐ Self ☐ Spouse ☐ Dependent	☐ Prescription ☐ Medical ☐ Vision ☐ Dental	_____
5.	_____	_____	☐ Self ☐ Spouse ☐ Dependent	☐ Prescription ☐ Medical ☐ Vision ☐ Dental	_____

Total _____

CERTIFICATION

I certify the accuracy of the above information contained in this claim form and that these claims are for the person covered under this Plan, and that I am not entitled to reimbursement from any other source.

Date _____ **Employee Signature**_____