

P.O. Box 211034 Eagan, MN 55121 Phone: 800-518-8332 Fax: 855-226-0680

## UNREIMBURSED EXPENSES CLAIM FORM

			Group Nan	ne:			
			Group Nui	mber:			
Employee's Full Name:			Date of Birth:			Employee Identification Number:	
			Mo. Day		Year		
			200				
Street Address			City State		e Zip		
Attach bills,	, receipts,	explanation of benefit	List Unreimbuts from other carrie	-		upporting claim doc	umentation.
Family Member	Age	Description of Expense			Service Provider SS# or Tax ID	Date Incurred Reimbursement From To Amount Requested	Amazonat Damoratad
						I	
				To	otal	\$	
I certify that all expenses this plan and that such e	s for which expenses l	n reimbursement is cla have not been reimbu	nimed were incurred rsed, or are not rein	d (i.e., service mbursable, u	es were provided) nder any other he	during a period whi alth plan coverage.	le I was covered under
I understand that I am fu	lly respon	nsible for the sufficienc	cy, accuracy and ve	eracity of all ir	nformation relating	g to this claim.	
Employee Signature					D	ate	
Daytime Phone Number Evening Phone Number							