STEWART'S SHOPS CORP.
MEDICAL REIMBURSEMENT ACCOUNT CLAIM VOUCHER

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

1. Complete this form and submit with your supporting documents.
2. 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.
3. Submit all documents to Kelly Bardin in the Personnel Department for reimbursement. Any questions you may contact Kelly at ext. 3335.
4. 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**______________________________