

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 Chris Pastore in the Personnel Department for reimbursement. Any questions you may contact Chris at ext. 3325.
4. Make a photocopy of all documents for your records.

Name of Employee (Last, First, Initial)

Social Security Number

UNINSURED MEDICAL OR DENTAL EXPENSES

	<u>Date Incurred</u>	<u>Name</u>	<u>Relationship</u>	<u>Description</u>	<u>Amount</u>
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____
7.	_____	_____	_____	_____	_____

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 _____

[For Administrative Use Only]

Approved for Reimbursement
Documentation & Math Checked

YES___ NO___ Initials _____ Date ____/____/____
Initials _____ Date ____/____/____