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HEALTH REIMBURSEMENT PLAN
REIMBURSEMENT FORM

Employer Name	Branch Location	Group No.
River Forest Public Schools District 90		**99001**

Employee's Last Name	First	M.I.	Birth Date (Mo./Day/Yr.)

Street Address	City	State	Zip Code

Telephone No.:	Social Security No.:

Health Reimbursement Expenses

1. Deductible* $_____ (Shown on EOB)

TOTAL AMOUNT REQUESTED **$_____**

**As described in the "Schedule of Covered Expenses" of the Summary Plan Description of this plan.*

Note: If your claim is for a dependent, you must provide:

a. Dependent's Name: _____

b. Dependent's Relationship to You: _____

You must attach a written statement from an independent third party stating that the above have been incurred and the amount of the expenses. **An explanation of benefits (EOB) from your group insurance plan administrator will satisfy this requirement.**

I certify that the above information is true and that the amount requested has not been reimbursed by any other plan or entity. Expenses listed above, qualify for reimbursement by me or by eligible members of my family.

Participant's Signature: _____ Date: _____