

**Moore College of Art & Design  
Medical Expense Reimbursement Plan  
Claimant' Statement**

Eligible employee name: \_\_\_\_\_

Claimant's name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Explanation of Charge(s): \_\_\_\_\_  
\_\_\_\_\_

Date charge incurred: \_\_\_\_\_

Total amount of charge: \_\_\_\_\_

Amount paid by health insurance: \_\_\_\_\_  
*(Attach original health insurance payment worksheet)*

Amount claimed for reimbursement: \_\_\_\_\_  
*(Attach original paid receipts in support of amounts claimed for reimbursement)*

I certify that all information presented in this claim or in support of the claim is true, correct and that this expense has not been paid or reimbursed by a group medical or prepayment plan.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

***Note: Medical expenses which have been paid or reimbursed under this plan are not deductible for federal or state income tax purposes.***

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**Payroll Office Use Only**

Reimbursement Amount \_\_\_\_\_

Account # \_\_\_\_\_

Prepared By \_\_\_\_\_

Date of Check \_\_\_\_\_