



**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.

Payroll Office Use Only

Reimbursement Amount _____

Account # _____

Prepared By _____

Date of Check _____