MAIL OR FAX TO: REIMBURSEMENT ACCOUNT
P.O. BOX 1140
EXETER, NH 03833-1140
PHONE: 888-678-3457
FAX: 603-773-4415

REIMBURSEMENT REQUEST FORM

HEALTH CARE ACCOUNT

- List reimbursable expense and attach explanation of benefits or itemized bill.
- Identify each expense as M (Medical), D (Dental), V (Vision), H (Hearing), or O (Other), under Type of Expense.
- If an expense is covered in part by a health plan the balance may be submitted for reimbursement only after all health plan benefits from all sources have been paid. A copy of the health plan's payment voucher or denial must be submitted with the claim. If no health plan applies write "none" in the Plan payment column.

NAME	Employee ID NUMBER 99-
ADDRESS (STREET)	EMPLOYER UNIVERSITY OF VERMONT
ADDRESS (CITY, STATE, ZIP CODE)	

EXPENSES FOR: DATES OF SERVICE:

TYPE OF EXPENSE	FIRST NAME	RELATIONSHIP	FROM	TO	TOTAL BILL (ATTACH COPY)	PLAN PAYMENT (ATTACH PAYMENT OR DENIAL)	AMOUNT REIMBURSEMENT DUE
			TOTALS				

1. I certify that the above listed expenses have been incurred by me or my eligible dependents (as defined by the IRS).
2. I certify that all applicable insurance or other health benefits have been exhausted.
3. I certify that I will not deduct or take as a tax credit on my Federal Income Tax Return these reimbursements.
4. I will assume all responsibility for taxes or penalties arising out of any disallowed deductions.

SIGNATURE:_____ DATE:_____

ALL CLAIMS FAXED/RECEIVED BY 12 NOON ON MONDAY WILL BE PROCESD/RD/R.6 (E PMaS35.5 8.8 WrrBU