MEDICAL REIMBURSEMENT VOUCHER

SOC SEC# _____ EMPLOYER: _____

EMPLOYEE NAME: _____
Last First MI

To: FLEXIBLE SPENDING DEPARTMENT

The undersigned participant in the plan requests reimbursement (attach proof of payment showing dates of service and date of payment in the form of itemized bills, receipts, and invoices for all expenses claimed) in the amounts shown below. If additional space is needed, please use back of form. If expense is incurred by my dependent, such dependent qualifies as a deduction on my federal tax return.

MEDICAL CARE EXPENSE

Date Incurred	Name of Service Provider	Describe Expense	Patient Name	Date of Birth	Amount Claimed

Total from reverse side: $_____

Total expenses claimed: $_____

READ CAREFULLY

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense which was incurred during the current plan year, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

Employee's Signature Date

Fax to: (901) 473-3266
Phone: (901) 473-3100

Mail to:
Pittman Employee Benefits
Attn: Billing Department
P.O. Box 111047
Memphis, Tennessee 38111