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

Eligible employee name: ____

Claimant's name: ______________________ Relationship: ________________

Explanation of Charge(s): ____

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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 ___________________