Out of Pocket Medical Expense Reimbursement Form

Date of Request: _____

Subsciber Name: _____

Individual or Family Plan _____

Plan Year _____

Total Out of Pocket Expenses	
Less $1250 for Individual Plan or $2500 for Family Plan	
Less Previous Reimbursements	
Reimbursement Requested	

Reimbursement request must be accompanied by a copy of the explanation of benefits

_____

Signature Date

_____

Processed By Date

Payroll or Voucher Date _____