FLEXIBLE BENEFITS PROGRAM

MEDICAL CARE EXPENSE CLAIM FORM

Employer Name (District):_____

Participant's Name:_____

Social Security Number:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Medical Plan Carrier:_____

The undersigned participant in the plan requests reimbursement in the amounts shown below:

NOTE: Federal law requires that you submit a written statement (such as an itemized bill from the benefit provider) as well as proof that the claim is not being reimbursed by an Insurance Company (Explanation of Benefit). Also, you will not be entitled to claim this expense as a tax deduction.

Date Incurred	Name of Service Provider	Describe Expense	Person for Whom Expense Incurred	Amount

Total this page: _____

Total from back: _____

Total amount of medical expenses/claims: _____

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 participant was covered under the Plan with respect to such expenses and that such expenses have not been reimbursed, or are not reimbursable, under any other health plan coverage. The participant fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to the claim which is provided by the participant, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the participant may be liable for the payment of all related taxes of amounts paid from the plan which relate to such expense. The participant further understands that no medical expense tax deduction or credit is permitted for amounts for which reimbursement is made.

_____ _____

Employee Signature Date

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Date Incurred	Name of Service Provider	Describe Expense	Person for Whom Expense Incurred	Amount

Total: _____

(enter here and on front of form)

BOARD OF COOPERATIVE EDUCATIONAL SERVICES

Send completed claim form to:

Flexible Benefits Program
Genesee Valley BOCES
80 Munson Street
LeRoy, NY 14482

Plan Administrator Use Only:

Payment Authorized_____
Check No._____
Amount_____
Date_____