

**HEALTH REIMBURSEMENT ARRANGEMENT
HEALTH CARE EXPENSE CLAIM FORM**

Participant's Identification No.: _____ Group Name.: _____

Participant's Name: _____ Group Number: _____
 First Middle Last

Claimant's Name: _____
 First Middle Last

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 other coverage. Also, you will not be entitled to claim any reimbursed expenses as a tax deduction. **Claims must be submitted to Rocky Mountain Administrators within 12 months of date of service to be eligible for reimbursement.**

HEALTH CARE EXPENSE

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

Total Amount of Medical	\$
--------------------------------	-----------

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 (i.e., services were provided) during a period while the undersigned 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 / Section 125 Flexible Benefit Plan. 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 under the Plan, the undersigned may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid from the Plan which relate to such expense. The undersigned further understands that no medical expense tax deduction or credit is permitted for amounts for which reimbursement is made.

_____ Date _____
 Participant's signature

SUBMIT TO:
ROCKY MOUNTAIN ADMINISTRATORS
 809 South Railway Avenue – P.O. Box 788
 Worland, WY 82401
 Phone – 307-347-2606 Fax – 307-347-2646