

**FORM TO:
DELPHI CARD
HEALTHCARE MANAGEMENT**

FSA

FAX: 847-516-9769

REIMBURSEMENT CLAIM FORM

PART A. CLAIMANT DATA

Name of Employer _____ Work Phone # _____

E-Mail _____

Name of Covered Employee _____ Social Security # _____

PART B. EXPENSES TO BE REIMBURSED

OUT-OF-POCKET, HEALTH CARE EXPENSES eligible for this plan (i.e. deductibles).

Description of Expense	Claim #	Family Member	Date Incurred	Amount of Claim
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**NOTE: SEND COPIES OF RECEIPTS SUPPORTING EACH LISTED ITEM OF EXPENSE.
RETAIN THE ORIGINAL RECEIPT AND A COPY OF THIS FORM FOR YOUR RECORDS.**

PART C. EMPLOYEE STATEMENT

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. The undersigned participant also certifies that amount claimed is not eligible for payment under any other health care plan or program, federal, state or government program, worker's compensation, or any other policy of health insurance. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and validity of all information relating to this claim which is provided by the undersigned. The undersigned further understands that no medical expense tax deduction is permitted for amounts for which reimbursement is made.

I authorize DELPHI CARD to pay these expenses.

EMPLOYEE SIGNATURE _____ DATE _____