

PLEASE MAIL OR FAX COMPLETED CLAIM FORM TO:
DELPHI CARD HEALTHCARE MANAGEMENT
MAIL: P.O. BOX 29, FOX RIVER GROVE, IL 60021-0029
FAX: 847-516-9769

HSA REIMBURSEMENT CLAIM FORM

PART A. CLAIMANT DATA

Name of Employer: _____ Work Phone #: _____
Email Address: _____ Home Phone #: _____
Name of Covered: _____ Social Security #: _____

PART B. EXPENSES TO BE REIMBURSED

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

Expense Desc. And Claim #	Family Member	Date Incurred	Claim \$\$\$	Pay This Money To:
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

NOTE: COPIES OF RECEIPTS SUPPORTING EACH LISTED ITEM OF EXPENSE MUST BE PROVIDED OR DELAY OF PROCESSING MAY OCCUR. 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/reimburse these expenses.

EMPLOYEE SIGNATURE: _____ DATE: _____