Unreimbursed Medical Reimbursement Claim Form

Employee Benefit Concepts, Inc.
A Group Resources Company
P.O. Box 511046
Livonia, MI 48151
(248)855-8040

Employer _____ Employee Name _____

Last 4 digits of Social Security Number _____ E-mail Address _____ Phone _____

Unreimbursed Medical Expense Claims

Date Expense Incurred	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount
➨ Attach appropriate receipt(s) and submit with this claim form.		Total Medical Care Expense Claim		$

Read Carefully: The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the Company's Cafeteria Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. 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 payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

Employee's Signature _____ Date _____

Send Form with Receipts attached to: Employee Benefit Concepts, Inc. ●P.O. Box 511046 ● Livonia, MI 48151 ● flexclaims@groupresources.com ● Phone 248-855-8040