Medical Expenses Reimbursement Form
American Benefit Services

Employee Information		
Last Name	First Name	SSN
Address		Check box if address is New: ☐
City	State	Zip
Daytime Phone	E-mail Address	Employer

Please attach Explanation of Benefits (EOB), receipts, bills or invoices that clearly identify the dates of service, the name of the provider, the service provided and the cost of the service.

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

Entire form must be completed. Please use separate sheet if more lines are needed.
All Claims must be listed out individually in full.

Date of Service	Person Receiving Service	Relationship	Type of Service	Total Reimbursement Requested
			Total Reimbursement Requested	

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 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 of city income tax on amounts paid form the Plan which relate to such expense. The undersigned further understands that no medical expense tax deduction is permitted for amounts for which reimbursement is made.

_____ _____

Signature Date

Send Claims to:
American Benefit Services
P.O. Box 1635
Irmo, SC 29063
Fax: 803-407-1649
Phone: 866-826-6554