KALAMAZOO COLLEGE
FLEXIBLE BENEFIT PLAN
REQUEST FOR HEALTH/MEDICAL REIMBURSEMENT FORM

EMPLOYEE_____ PHONE #: _____

ADDRESS_____
☐ ***(Please check if this is a new address.)***

CITY _____ STATE _____ ZIP _____

HEALTH/MEDICAL REIMBURSEMENT

Complete one line for each expense you wish reimbursed under your Medical Reimbursement Account.
Please attach itemized bill as support for the claimed amounts.

TYPE OF SERVICE MED, RX, OV, DENTAL, or VISION	**SERVICE DATE** Ex; 1/15/11 – 2/07/11 Must List Date/s	**PROVIDER** Name of Doctor or Pharmacy	**AMOUNT** Total Dollar Amount NOT covered by insurance
		TOTAL AMOUNT 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 KALAMAZOO COLLEGE FLEXIBLE BENEFIT PLAN with respect to such expenses and that such 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 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.

_____ _____
Employee's signature ***Date***

Mail to: JFP Benefit Management, Inc. - P.O. Box 189 - Jackson, Michigan 49204 (800)-589-7660 or (517) 784-0535
Fax (517)784-0821 or Email krichardson@JFPBenefitManagement.com