



Police & Fire Retiree Medical Trust

Health Reimbursement Request Form

Check if new Address

Name: _____
 Address: _____

Retiree ID: _____
 Phone: _____
 Email: _____

Instructions: Complete the information below for reimbursement of medical expenses incurred by you or your eligible dependents. You must provide substantiation of medical expenses such as hospital or doctor bills or other evidence that the expenses were paid. If the Form is incomplete, it will be returned to you. Please sign and date the Form and send it along with your supporting documentation to the Plan Administrator.

	Example	Expense #1	Expense #2	Expense #3	Expense #4	Expense #5
Date medical service actually provided	7/4/2008					
Name of person receiving medical service and his/her relationship to you	J. Doe <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input checked="" type="checkbox"/> Dependent	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent
Proof of expense attached	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Total Expense	\$100.00					
Amount reimbursed previously or paid/ payable under another plan	\$0					
Reimbursement Requested	\$100.00					

To the best of my knowledge and belief, my statements in this Form are complete and true. I certify all of the following: Either I have or my family member has received the services described above on the dates indicated, and the expenses are my out of pocket expenses that qualify as eligible Medical Care Expenses under the Plan. If the expense is for my Spouse or Dependent, the person listed is my Spouse or Dependent as defined by the Plan. I have not been reimbursed previously for these expenses. These expenses have not been reimbursed or are not reimbursable under the major medical plan or any other health plan. If the reimbursement requested is for prescribed drugs, such drugs are not prescribed for cosmetic purposes (hair growth, weight loss, etc.). I understand that the expenses reimbursed may not be used to claim any federal income tax deduction or credit, or to claim reimbursement under another medical plan. I authorize a deduction from my HRA Account in the amount of the requested reimbursement.

Retiree Signature _____

Date _____

For Office use only	Amount Approved	Date Approved	Approved by:
Reason Expense Denied:			