SANTA ROSA COUNTY
FLEXIBLE BENEFITS PLAN
HEALTH CARE REIMBURSEMENT CLAIM FORM

____ **Please check if address change**

Social Security No: _____

Participant's Name: _____ Daytime Telephone Number: _____

Participant's Address: _____

The undersigned participant in the plan requests reimbursement in the amounts shown below☹If additional space is needed, use the reverse side of the form.) ***Please attach receipts, bill or invoices.***

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.

Service	Service Provider	Expense	Expense Incurred	Amount
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Total amount of health care expenses (including amounts from reverse side). $_____

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 claims 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 is permitted for amounts for which reimbursement is made.

_____

Employee's Signature *Date*

Send claims to:
Lockard & Williams Insurance Services, P.A.
P.O. Box 1028
Gonzalez, FL 32560
Fax (850) 479-2923

Phone (800) 530-7222

HEALTH CARE EXPENSE

Date of Service	Name of Service Provider	Describe Expense	Person for Whom Expense Incurred	Net Amount

TOTAL $____________