Please fax completed form to: (973) 529-0372

Unreimbursed Medical Reimbursement Claim Form

CDH PLANS

Toll Free: (877) 505-9500
Fax: (973) 529-0372
www.cdhplans.com

Employer:_____

Employee Name:_____ Social Security Number:_____

Phone:_____ E-mail:_____

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