

ALBRIGHT COLLEGE

MEDICAL WAIVER PLAN CLAIM FORM

Plan Participant _____
(please print)

The Albright College Medical Waiver Reimbursement Plan covers only the employee and does not include reimbursement for dental and vision expenses. The Plan Year is defined as June 1 through May 31 which coincides with the College's fiscal year. The maximum reimbursement cannot exceed \$1,500.00 per fiscal year.

According to the privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA) all protected health information (PHI) will continue to be confidential and safeguarded exclusively with Human Resources.

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 Albright College Medical Waiver Reimbursement Plan with respect to such expenses that such expenses have not been reimbursed, or are not reimbursable, under any other health plan coverage up to an amount not to exceed \$1,500.00 per fiscal year. 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 participant in the plan requests reimbursement in the amount shown on the attached sheet.

Participant's signature

Date

For Plan Administrator use only:

Reimbursement Plan	Amount Authorized	Natural Code
<input type="checkbox"/> Medical Waiver	\$ _____	01-000000-1001-xxxxx -14240
<input type="checkbox"/> Reimbursement is Not Qualified.	\$ _____	See attached explanation

Claim Reviewer

Supervisor

Plan Administrator

Controller's Office

MEDICAL WAIVER/FLEXIBLE SPENDING ACCOUNT PLAN EXPENSE CLAIM FORM

DATE INCURRED	PARTICIPANT/DEPENDENT NAME FOR WHOM EXPENSE INCURRED	NAME OF SERVICE PROVIDER	AMOUNT
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____

IMPORTANT: IRS Regulations require that you submit a written statement (such as an itemized bill or explanation of benefits statement from the benefit provider) for claim verification. Please attach documentation to this form.

Reimbursement Not Qualified:

Claim Reviewed Date