ORLEANS CENTRAL HEALTH REIMBURSEMENT ARRANGEMENT AND HEALTH SAVINGS ACCOUNTS

Health Care Expense Claim Form

Name (last, first, MI)	Social Security #

The undersigned Participant in the Plan requests reimbursement in the amount shown below (please list individually on the reverse side):

- invoices or receipts which indicate the name and address of the service provider, name of employee or dependent for whom the service was provided, date of service, type of service or product provided and amount of expense. ***Prescription drugs require the receipt from the pharmacist (a cash register receipt <u>is not</u> sufficient).*** *Over-the-counter (OTC) drugs (purchased for medical purposes) require an invoice or receipt (a cash register receipt <u>is</u> sufficient with the drug(s) and/or items identified.*

Total Amount of Medical Expenses (from page 2 of this form): $_____

IMPORTANT

The undersigned participant in the plan certifies that all expenses for which reimbursement or payment are claimed by submission of this form, were incurred during a period in which the undersigned was covered under the Orleans Central Health Reimbursement Arrangement 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 is permitted for amounts for which reimbursement is made. Furthermore, the undersigned agrees that any amounts paid which are in excess of his or her current account balance will be considered a loan and will be owed to the Plan in the event he or she terminates employment (for any reason) prior to the completion of the current Plan Year.

Participant's Signature	Date

Please return completed form to:

Future Planning Associates, Inc.
ATTN: Orleans Central Administrator
P.O. Box 905
Williston, Vermont 05495-0905
Phone: (802) 857-0685; ***Scan & e-mail****:* ***belinda@futureplanningassoc.com***
FAX: 802/857-0705 – If faxing or scanning this request, to avoid duplication, **DO NOT** mail.

Itemized List of Expenses
Health Insurance Premiums are NOT a permitted Health Care expense

Date Incurred	Name of Service Provider	Description of Expense	Person for Whom Expense Incurred	Net Amount
				$
				$
				$
				$
				$
				$
				$
				$
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				$
				$
Total (enter here and on page 1 of this form)				$