ROCKY MOUNTAIN ADMINISTRATORS
809 South Railway Avenue – P.O. Box 788
Worland, WY 82401
Phone – 307-347-2606   Fax – 307-347-2646

FLEXIBLE SPENDING VOUCHER
MEDICAL CARE EXPENSE CLAIM FORM

Participant's Social Security No.: ________________________ Group Name.: ____________________

Participant's Name: ____ Group Number: _______
(First Middle Last)

Claimant's Name: ____
(First Middle Last)

The undersigned participant in the Plan requests reimbursement in the amounts shown below:
NOTE: Federal law requires that you submit a written statement (such as an itemized bill from the benefit provider) as well as proof that the claim is not being reimbursed by other coverage. Also, you will not be entitled to claim any reimbursed expenses as a tax deduction.

MEDICAL CARE EXPENSE

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

Total Amount of Medical	$

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 (i.e., services were provided) during a period while the undersigned was covered under the Plan 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 or credit is permitted for amounts for which reimbursement is made.

__________________________________ Date_________________________
Participant's signature