CRIDER INSURANCE SERVICES

6300 Ridglea Place Suite 315 Fort Worth, TX 76116
(800) 466-2324 * (817) 735-8304 * Fax (817) 735-8301

HEALTH CARE EXPENSE CLAIM FORM

Social Security No:______________________________________

Participant's Name:______________________________________

To: Crider Insurance Services – Plan Administrator

The undersigned participant in the plan requests reimbursement (attach itemized bills, receipts, and invoices for all expenses claimed) in the amounts below: (If additional space is needed, please use the back of this form.)

MEDICAL CARE EXPENSE

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

Total expenses from reverse side: $___________

Total amount of medical expense: $___________

PLEASE 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 employer's Cafeteria Plan with respect to such expenses and 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 prior 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

For Plan Administrator Use:

Payment Authorized:____________ Check No.______________
Amount $______________________ Date:__________________