Employer Name

Employee Information

Name (Last, First, Middle Initial)

Address (Street)

Employee Email Address

Names of Dependents

Dependent Name	DOB	Relationship

Employee Signature

Date

Please Note: ! "#$$

nyhart

w

%
&
1 0 #PY
,BOTBT $JUZ .0
3
#1'''1''4122/#
#1'$$10'(1'(#0
.#41'()1 567 .).2

Expenses to be Reimbursed

Type of Expense	Date Incurred	Amount
	Total	0
	Total	0
	Total	0
	Total	0
	Total	0

Instructions for Filing a Claim

For medical/dental/vision expense claims that were submitted to a health plan or an insurance company but were not f