Claim for Medical Deductible Reimbursement Plan

Street Name: _____ ☐ **Please check here if you have had a recent change of address:**

City, State and Zip: _____ Employer: _____

Name _____ Social Security # _____

Medical Deductible Expense Claims

Date Expense Incurred	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount
		TOTAL MEDICAL DEDUCTIBL EXPENSE CLAIM		

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 Company's Medical Reimbursement Plan with respect to such expenses and that 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 proper 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

Please note: Direct Deposits are normally available two (2) banking days after processing. It is your responsibility to verify deposits before writing checks against these funds. Neither your employer, nor HR Butler and its banking affiliates, are responsible for bank errors or bank fees.

Phone number: 614-799-0566 X118 Fax number: 614-799-0544 63 Corbins Mill Dr. Dublin, OH