Mail To: Administrative Services, Inc.
P. O. Box 590
Rochester, IL 62563

E-mail To: cafe@asi-tpa.com
Fax To: 217-498-8481

Company Name:_____

Medical Care Reimbursement Claim Form

ID#:(first 4 last name - last 4 SS#) __ __ __ __ __ __ __ __ Employee #:_____

Participant's Name:_____
Last First Middle

To: Administrative Services, Inc.

The undersigned participant in the plan requests reimbursement in the amount(s) shown below. Completion of this claim form serves as a written statement that the expenses have not been reimbursed and are not eligible for reimbursement under any other health coverage and that any OTC medications claimed have been and are currently prescribed by a doctor. The undersigned participant has also attached itemized bills, receipts, and/or invoices for all expenses claimed.

HEALTH CARE EXPENSE

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

Use back of form for additional space - Amount from other side $_____

Total amount of health care expense $
=========

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 above company's plan with respect to such expenses. 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 tax on amounts paid from the plan which relate to such expense.

_____

Employee's Signature **Date**

For Plan Administrator use only: Batch No:_____
Payment Authorized _____ Check No:_____
Amount $_____ Date:_____

MEDICAL CARE EXPENSE CLAIM FORM

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

Total (enter here and on front of form) $ `