WEST VIRGINIA WESLEYAN COLLEGE
CAFETERIA PLAN

MEDICAL CARE EXPENSE CLAIM FORM

Employee No.: ______________________________

Participant's Name: ____
Last First Middle

The undersigned participant in the Plan requests reimbursement in the amounts shown below: (If additional space is needed, please use the additional second sheet.)

NOTE: Federal law requires that you submit a written statement (such as an itemized bill from the provider) as well well as proof that the claim is not being reimbursed by an Insurance company. Also, you will not be entitled to claim this expense as a tax deduction.

MEDICAL CARE EXPENSE

Date Incurred	Name of Service Provider	Describe Expense	Person for Whom Expense Incurred	Net Amount
________	________________________	________________	________________	$ ________________
________	________________________	________________	________________	$ ________________
________	________________________	________________	________________	$ ________________
________	________________________	________________	________________	$ ________________
________	________________________	________________	________________	$ ________________
________	________________________	________________	________________	$ ________________
________	________________________	________________	________________	$ ________________

Amount from attached form: $ ________________

Total amount of medical 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 West Virginia Wesleyan College Cafeteria 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 no medical expense tax deduction or credit is permitted for amounts for which reimbursement is made.

____ Date: ______________________________
Employee's signature

For Plan Adminstrator use only	For Employer use only
Payment Authorized: ________________	Check No.: __________________________
Amount Authorized: $ ________________	Date: ______________________________