



Allied Benefit Systems, Inc.
 208 S. LaSalle St. Suite 1300
 Chicago, IL 60604
 Tel 312-906-8080
 Fax 312-416-2870
 www.alliedbenefit.com



**UNREIMBURSED MEDICAL EXPENSES
 REIMBURSEMENT REQUEST FORM**

Employer Name THSD 214		Employee Type		Group No. A06157
Employee's Last Name		First	M.I.	Birth Date (Mo./Day/Yr.)
Street Address		City	State	Zip Code
Social Security No.		Telephone No.:		Sex: Male Female
Unreimbursed Medical Expenses				
1. Deductible/Co-Insurance				\$
2. Drugs and Medications				\$
3. Other Medical Expenses				\$
4. Dental Expenses				\$
5. Vision Expenses				\$
6. Other:				\$
TOTAL AMOUNT REQUESTED				\$
<p>Note: If your claim is for any Unreimbursed Medical Expenses incurred by a dependent, you must provide:</p> <p>a. Dependent's Name:</p> <p>b. Dependent's Relationship to You:</p> <p>c. Dependent's Date of Birth:</p>				
<p>You must attach a written statement from an independent third party stating that the unreimbursed medical expenses above have been incurred and the amount of the expenses. An explanation of benefits from your group insurance plan administrator will satisfy this requirement. Canceled checks are not acceptable.</p>				
<p>I certify that the expenses listed above qualify for reimbursement and have been incurred and paid by me or by eligible members of my family. These expenses have not been reimbursed by my health care plan or any other health care plan, such as my spouse's. Bills, statements or other evidence of these expenses are attached.</p>				
Participant's Signature: _____				Date: _____