Reimbursement Request Form

Employer Name	CITY OF RIPON

Employee Information ☐ *PICK UP CHECK* ☐ *MAIL CHECK TO ADDRESS BELOW*

Last Name	*First*	*Middle Initial*
Home Address	*City/State*	*Zip Code*
Home Phone	*Work Phone*	*Date of Birth*

Items required in submitting this form:

(1) Complete all pertinent information in the spaces provided, sign, date and return to Geri VanGorkum in the Payroll/HR Dept.

(2) Attach an itemized Explanation of Benefits (EOB) or receipt from Insurance Carrier/Provider to support requested reimbursements.

(3) EOB/RECEIPT MUST INCLUDE: Date of service, description of expense, cost of expense, and amount patient responsible for clearly listed for approval.

Date of Expense	***Type of Expense***	***Expense Incurred By***	***Requested Amount***
Total Medical Requested			

Approved	YTD – Deductible
Date	YTD – Coinsurance

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 plan with respect to such expenses; and that such expenses have not been reimbursed, or are not reimbursable, under any other benefit plan coverage. The undersigned fully understands that he or she alone is 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 participant also acknowledges that the participant alone is responsible for direct payment to the service provider of the expense being requested for reimbursement and that the employer, the plan or the plan administrator will not be liable for any lack of payment to the service provider should the participant fail to submit payment for the expense to the service provider after receiving reimbursement from the Plan.

Employee Signature _____ Date _____

A/P VENDOR #25822

acct_____ $_____

acct_____ $_____

acct_____ $_____

acct_____ $_____