Unreimbursed Medical Reimbursement Claim Form
2008 Mileage Only Report

To expedite your claim:
➢Provide *all* appropriate information
➢Review the Total before printing.

Employer:_____ Fax: Page 1 of_____

Employee Name: _____ Phone Number:_____

Social Security Number:_____ E-mail:_____

Unreimbursed Medical Expense Claims Mileage

Date Travel Incurred	Name of Facility/Destination	Total Mileage Traveled	Effective July 1, 2008 IRS Allowable per mile $.27	Net Amount
Totals				
Medical Care Expense Mileage				

Read Carefully : The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the Company's Cafeteria Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimburse able 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 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

Send Completed Form to:
Section 125 Department
Employee Benefit Concepts, Inc.
P.O. Box 2365
Farmington Hills, MI 48333

claims@employeebenefitconcepts.com
Fax-248-855-2454
Phone-248-855-8040