

MEDICAL REIMBURSEMENT CLAIM FORM

EMPLOYER NAME

State of Rhode Island

EMPLOYEE INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER
STREET ADDRESS	CITY	STATE	ZIP
DATE OF BIRTH	WORK PHONE	HOME PHONE	EMAIL ADDRESS

UN-REIMBURSED MEDICAL EXPENSE CLAIMS

Date Expense Incurred	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount
➤ Attach appropriate receipt(s) and submit with this claim form.			TOTAL MEDICAL CARE EXPENSE CLAIM	\$

***PLEASE DO NOT SEND ORIGINAL RECEIPTS/STATEMENTS

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 Company's Flexible Spending Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan. 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 income tax on amounts paid from the Plan which relate to such expense.

EMPLOYEE SIGNATURE

SIGNATURE	DATE
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Mail or Fax claims to:

Cornerstone Administrative Services, LLC - Attention: Flex Claims Department
 1350 DIVISION ROAD, SUITE 301 WEST WARWICK, RI 02893 TOLL FREE PHONE: (800) 720-4460 TOLL FREE FAX: (866) 878-2800
 (You may copy this form if additional forms are needed)