

# KLAIS & COMPANY, INC.

EMPLOYEE BENEFIT CONSULTANTS AND ADMINISTRATORS

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## STATEMENT OF CLAIM FOR HEALTH REIMBURSEMENT ARRANGEMENT

### I. GENERAL INFORMATION - COMPLETE ALL INFORMATION AS REQUESTED.

Your Employer \_\_\_\_\_ Soc Sec. # \_\_\_\_\_

Your Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Home Address \_\_\_\_\_  
Street City State Zip

### II. FOLLOW THE DIRECTIONS BELOW FOR HEALTH REIMBURSEMENT

If you have health care expenses which you submitted to your group health plan which were not reimbursed due to deductibles, simply attach a copy of the Explanation of Benefits (EOB) form.

### III. EMPLOYEE CERTIFICATION - READ AND SIGN THIS SECTION

I certify that the information accompanying this form is for true and correct health care expenses on myself or my legal dependents. I understand that any expenses reimbursed from this account are not tax deductible on my Federal Income Tax Return. I certify that these expenses have not been paid, and are not payable, under any other group benefit plan.

Date: \_\_\_\_\_ 20 \_\_\_\_\_ Signature of Employee \_\_\_\_\_