HEALTH CARE SPENDING ACCOUNT
Claim for Reimbursement

NAME OF EMPLOYER		
EMPLOYEE NAME		SOCIAL SECURITY NUMBER
EMPLOYEE ADDRESS	STREET	CITY
STATE	ZIP	PHONE NO:

HEALTH CARE EXPENSES

PATIENT NAME	DATES OF SERVICE FROM	TO	PROVIDER OF SERVICE	(A) TOTAL CHARGE	(B) AMOUNT PAID BY OTHER SOURCES	(A-B) AMOUNT TO BE REIMBURSED
					TOTALS	

CERTIFICATION

I certify that the expenses for which I am requesting reimbursement meet all of the conditions listed below:
- They were incurred for services or supplies received by me or my eligible dependents under the plan.
- They were for services or supplies furnished while I was a participant in the Plan.
- I have not been reimbursed for these expenses, and they are not reimbursable from any other health plan.

I understand that reimbursement of these expenses can be requested and made only after I have collected all benefit payments available from all plans under which my eligible dependents and I are covered. I further certify that I have not deducted nor will deduct on my individual income tax return any of the expenses reimbursed through my Health Care Spending Account.
I understand that reimbursement will be made in accordance with the provisions of the plan which I participate. I accept responsibility for the proper treatment of benefits paid under this plan with respect to eligibility, income tax reporting, and liability.

EMPLOYEE SIGNATURE	DATE

COMPLETION OF CLAIM FORM

- Complete all information on the claim form for each amount claimed for reimbursement.
- Make sure the claim does not include items for more than one plan year.
- You must sign and date claim form.
- A copy of a bill or other written statement from the provider of service is acceptable only when **NO other insurance is applicable**.
- Cancelled checks/Credit Card Statement are NOT acceptable.
- If insurance is applicable, a statement/explanation of benefits from ALL MEDICAL/DENTAL INSURANCE CARRIERS SHOWING DEDUCTIBLE, COPYMENTS AND PAYMENTS IS REQUIRED.

MAIL COMPLETED FORM TO:

BROWN & BROWN of NEW YORK, INC.
DBA FITZHARRIS & COMPANY
333 Earle Ovington Blvd., Suite #215
Uniondale, NY 11553-3624
(516) 944-2823; FAX (516) 944-2953