Employee Health Insurance Management

Flexible Spending Account for:
C.O.P.E.S.D.
Health Care Reimbursement Request

1. Complete Parts A & B in full.
2. Attach copy of Explanation of Benefits (EOB) for deductible and coinsurance reimbursement requests. Claims must be submitted to all appropriate insurances before they may be processed through your Flexible Spending Account.
3. Attach itemized bills for expenses not covered by medical/dental insurance.
4. Submit bills to EHIM, 26711 Northwestern Highway, Suite 400, Southfield MI 48033
5. All claims submitted for reimbursement MUST be paid by you BEFORE they are eligible for reimbursement. Proof of payment in the form of a copy of a cancelled check or paid provider statement MUST accompany your request for reimbursement.

Part A: Failure to answer all questions may cause a delay in payment.

Employee Name:	**Social Security #:**
Address (Street, City, State & Zip):	
Date of Birth:	**Employer Name:**
Home Phone:	**Work Phone:**

Dependent Name	Date of Birth	Gender	Relationship to Insured	Are you entitled to an Income Tax Deduction for this dependent
1.		M F		Yes No
2.		M F		Yes No
3.		M F		Yes No
4.		M F		Yes No

Part B: Reimbursement Request

1. Total Health Care Expenses Incurred:	**$**
2. Amount Paid by your employer's plan and/or other insurance:	**$**
3. Balance to be considered under the Flexible Benefits Account:	**$**

I hereby request that the expenses shown above to be considered for payment. I certify that these expenses are not eligible for payment under any insurance plan. I understand that any expenses reimbursed are not tax deductible on my Federal Income Tax Return.

_____ _____

Employee Signature **Date**