Southeastern California Conference
Human Resources
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HEALTH CARE REIMBURSEMENT FORM

1. A separate claim form must be completed for each member.
2. Part A and B must be completed and signed.
3. Itemized statements and receipts accepted.
4. Please note incomplete forms will be returned.

PART A - Completed by the main subscriber of the medical insurance

(Be sure to complete each item to avoid a delay in the payment of your claim)

EMPLOYEE NAME: *(Last, First, M.I.)* DOB: *(Date of Birth)*:

ADDRESS: *(Please complete the address section if your information needs updating.)* ☐ Yes ☐ No

IS THE CLAIM FOR A DEPENDENT? ☐Yes ☐No If Yes, give name: _____

☐ Spouse — Date of Birth: _____ ☐ Child — Date of Birth: _____

PART B – Submit copies of original receipts and itemized statements for each claim, arranged by date.

TYPE	DATE OF SERVICE	SERVICE RECIEVED/PROVIDER	AMOUNT	OFFICE USE ONLY
Vision				
Lasik				
Hearing Aid				
Exceptions				

I certify that the attached itemized bills and paid receipts are for out-of-pocket HCAP expenses (vision, hearing, and "exceptions") for me personally or for my eligible dependents, and authorize the providers of medical services to release my information relative to the treatment or billing on these items.

SIGNATURE:_____ DATE:_____