RP Riley Management Group, Inc.

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UNREIMBURSED MEDICAL EXPENSES
REIMBURSEMENT REQUEST FORM

Employer Name	Branch Location		Group No.
Employee's Last Name	First	M.I.	Birth Date(Mo/Day/Yr.)
Street Address	City	State	Zip Code
ID No.	Telephone No.		Sex: ☐ Male ☐ Female

Unreimbursed Medical Expenses

1	Deducible/Co-Insurance	$
2	Other Medical Expenses	$
3	Dental Expenses	$
4	Vision Expenses	$
5	Other:	$
TOTAL AMOUNT REQUESTED		**$**

Note: If your claim is for any Unreimbursed Medical Expenses incurred by a dependent, you must provide:

a Dependent's Name: _____

b Dependent's Relationship to You: _____

c Dependent's Date of Birth: _____

You must attach a written statement from an independent third party stating that the unreimbursed medical expenses above have been incurred and the amount of the expenses. An explanation of benefits from your group insurance plan administrator will satisfy this requirement. Canceled checks are not acceptable.

I certify that the expenses listed above qualify for reimbursement and have been incurred and paid by me or by eligible menbers of my family. These expenses have not been reimbursed by my health care plan or any other health care plan, such as my spouse's. Bills, statements or other evidence of these expenses are attached.

Participant's Signature: _____ Date: _____