BAUGHER FINANCIAL & ASSOCIATES, INC.

Employee Benefits Consulting & Financial Services

HEALTH REIMBURSEMENT REQUEST FORM

Employee Name: ______________________________

Dependent Name(s) (if other than member): ________________

Employer: **Massac County Until School District #1**

Home Address: ______________________________

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Tel: ____________________ Email: ____________________

*YOU MUST INCLUDE THE **EXPLANATION OF BENEFITS or CLAIM DETAIL** FROM THE INSURANCE COMPANY IN ORDER FOR REIMBURSEMENT*

Signature of Member: ______________________

Date: ______________________

By signing this request for reimbursement, I give the plan administrator or its duly authorized 3rd party the right to obtain private healthcare information, but such authorization may be limited to information directly related to this request. If a request for reimbursement is not accompanied by valid documentation, the request will be declined. You will receive notice that your request was incomplete or denied.