

FLEXIBLE BENEFITS PLAN

Medical Care Expense Claim Form

Participant's Name: _____
Last First Middle

Social Security No.: _____ Daytime Telephone No.: _____
(optional)

E-Mail Address: _____

Fax to: (845) 677-2507 or Mail to: Malleolo Associates, Inc.
2510 Route 44, Suite 11
Salt Point, NY 12578
Attn: Flexible Benefits

Tel: (845) 677-2363

The undersigned participant in the plan requests reimbursement in the amounts shown below: (If additional space is needed, please use the reverse side of this sheet.)

NOTE: Federal law requires that you submit a written statement (such as an itemized bill from the benefit provider) as well as verify that the claim is not being reimbursed by an Insurance Company. Also, you will not be entitled to claim this expense as a tax deduction.

MEDICAL CARE EXPENSE(S)

| Date Incurred | Name of Service Provider | Describe Expense | Relationship to Employee of Whom Expense is For | Net Amount |
|---------------|--------------------------|------------------|---|------------|
| _____ | _____ | _____ | _____ | \$ _____ |
| _____ | _____ | _____ | _____ | \$ _____ |
| _____ | _____ | _____ | _____ | \$ _____ |
| _____ | _____ | _____ | _____ | \$ _____ |

Amount from reverse side: \$ _____

Total amount of medical expenses: \$ _____

READ CAREFULLY

The undersigned participant in the plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form, were incurred during a period while the undersigned was covered under "The Company" Flexible Benefits Plan with respect to such expenses and that such expenses have not been reimbursed, or are not reimbursable, under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid from the plan which relate to such expense. The undersigned further understands that no medical expense tax deduction or credit is permitted for amounts for which reimbursement is made.

Employee's Signature Date: _____

For Plan Administrator Use Only

Payment Authorized: _____ Amount \$: _____

