ESS EMPLOYER SUPPORT SERVICES, INC.

# Health Reimbursement Claim Form

Claims must be incurred during this Plan Year

Name:_____ Social Security Number:_____ - _____ - _____

## Health Care Request

You must complete the section below and attach a copy of the provider's bill or insurance company's "Explanation of Benefits" verifying the date of service, type of service, name of person receiving service, and the cost.

| Date | Type | For Whom | Relationship | Cost |
|---|---|---|---|---|
| _____ | _____ | _____ | _____ | $_____ |
| _____ | _____ | _____ | _____ | $_____ |
| _____ | _____ | _____ | _____ | $_____ |
| _____ | _____ | _____ | _____ | $_____ |
| _____ | _____ | _____ | _____ | $_____ |
| _____ | _____ | _____ | _____ | $_____ |
| _____ | _____ | _____ | _____ | $_____ |
| _____ | _____ | _____ | _____ | $_____ |
| _____ | _____ | _____ | _____ | $_____ |

Total Health Care amount Requested (Amount that is <u>your</u> responsibility) $_____

To the best of my knowledge and belief, my statements on this request for Reimbursement are complete and true. I understand that I am solely responsible for the validity of claims submitted. I am claiming reimbursement only for eligible expenses incurred by myself or dependent covered on my employer sponsored group health plan. I certify that these expenses have not been reimbursed under this plan or by any other source and that they will not be reimbursed by any other source or insurance.

I herby authorize my health reimbursement balance to be reduced by the amount(s) shown above.

Participants Signature _____ Date_____

For assistance please call the benefits department at 225-766-2622 or 1-800-535-7206.

Send this form and documentation to:
ESS
Benefits Dept.
8530 Anselmo Lane
Baton Rouge, LA 70810
or
Fax 225-761-1002