HEALTH REIMBURSEMENT ARRANGEMENT (HRA) - CLAIM FORM

Regional Care, Inc.
905 West 27th Street
Scottsbluff, NE 69361
Phone: (308) 635-2260 or (800) 795-7772
Fax: (308) 635-1241

EMPLOYEE INFORMATION

Name:____________________________ Soc.Sec.#:_______________________

Phone:___________________ Employer:_______________________________

HEALTHCARE EXPENSE CLAIMS

Date Expense Incurred	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Amount of Expense

TOTAL:_____________

READ CAREFULLY: The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the Company's Health Reimbursement Arrangement with respect to such expenses and that the medical expenses have not been and will not be reimbursed 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 payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

Your Health Reimbursement Arrangement (HRA) Plan may be limited to the types of healthcare expenses that may be reimbursed to you. Please read the Summary Plan Description for your HRA Plan for a list of eligible expenses.