INTEGRITY ADMINISTRATORS, INC.
SUPPLEMENTAL MEDICAL REIMBURSEMENT ACCOUNT (SMRA)
REIMBURSEMENT REQUEST FORM

Employer: ____

Employee Name & Address

Last Name: ________________________ **First Name:** ________________________ **M. I.** ____ ☐ **Male** ☐ **Female** **Phone #:** (____) ______ -- ______ **Employee # or SSN #:** _____/_____/_____

Street: ____ **City:** ____________________________ **State:** _______ **Zip Code:** _________

Instructions: *Complete the information below for Expenses incurred by you, your Spouse, or your other eligible Dependents. For information as to what Expenses can and cannot be reimbursed, and for the special rules that apply to claims for expenses incurred during any Applicable Grace Period, see the Salary Reduction Plan Summary Description. You must provide insurance Explanation of Benefits (EOB's), hospital or doctor bills, pharmacy receipts, or other evidence from independent third parties that the Expenses were incurred (canceled checks or balance due not acceptable). Be sure to provide all information requested by this Form. If the Form is incomplete, it will be returned to you.*

	Expense #1	**Expense #2**	**Expense #3**	**Expense #4**	**Expense #5**	**Expense #6**
Date medical service or item actually provided:						
Name of person receiving medical service:						
His/her relationship to employee:	☐ Self ☐ Spouse ☐ Dependent	☐ Self ☐ Spouse ☐ Dependent	☐ Self ☐ Spouse ☐ Dependent	☐ Self ☐ Spouse ☐ Dependent	☐ Self ☐ Spouse ☐ Dependent	☐ Self ☐ Spouse ☐ Dependent
Type of service (Medical, Rx, Etc):						
Proof of expense is attached (including name or type of medicine or drug):	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Total Expense:	$	$	$	$	$	$
Amount paid or reimbursed by another plan: (attach a copy of EOB)	$	$	$	$	$	$
Reimbursement Requested:	$	$	$	$	$	$
					Total Reimbursement Requested:	$

I authorize the above expenses to be reimbursed from my Supplemental Medical Reimbursement Account. To the best of my knowledge, my statements on this Form are true and complete. I certify all of the following:

- The expenses qualify as valid Medical Care Expenses under Code §213 (d), as defined in the Salary Reduction Plan document ("The Plan"). These expenses must not be for cosmetic purposes, are not incurred for general health purposes, and do not constitute toiletries.
- These expenses have not previously been reimbursed under the Supplemental Medical Reimbursement or any other plan, and I will not seek reimbursement for them under the Medical Insurance Plan or any other health plan.

In addition, I understand that I may be asked to provide further details about some expenses (e.g., a medical practitioner's statement that an expense is to treat a specific medical condition, or a more detailed certification from me).

X: ____ ____________________________

Employee Signature Date

Please Make Sure to Sign and Date This Form, Then Send It or Fax It Along With Your Supporting Documentation To:

Integrity Administrators, Inc.
P.O. Box 13128 Sacramento, CA 95813
(916) 921-3388 (800) 562-9383 Fax: (916) 921-3383