HAMDEN BOARD OF EDUCATION
Medical Expense Reimbursement Plan
Application For Reimbursement

Nature of Medical Expense: _____

_____

Date(s) Expense Incurred: _____

Amount of Reimbursement: _____

Reimbursement check to be paid to: _____

_____

I hereby certify that the above listed Medical Expense has not been (and shall not be) reimbursed from any other source.

_____ _____

Date *Signature of Employee*

For Internal Use By Third Party Administrator Only

Date Claim Submitted: _____

Date Claim Paid: _____

Amount of Check: _____

Check #: _____