Request for Reimbursement
VISION CLAIM FORM

(Please print or type)

Name	Last First MI	**SS#:**	
Address	Street City State ZIP	**Phone**	( )
Company	Catholic Diocese of Jackson	**E-mail**	

❑ ***Please check if this is a new address.***

VISION EXPENSE CLAIMS

Date of Service MM/DD/YY	Patient Name	Relationship	Name of Provider	Description of Service	Claim Amount
					$
					$
					$
					$
				Total:	$

DEPENDENT CARE VISION CLAIMS

Date of Service From	To	Dependent Name	Age	Dependent Care Provider Name	Dependent Care Provider Address	Provider Tax Id#/SS#	Claim Amount
							$
							$
							$
						Total:	$

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature: _____ Date: _____ /_____ /_____

For fastest reimbursement email to LMansfield@abadmin.com
Or fax to (915) 532-1772
Or mail to:
Assured Benefits Administrators
221 N. Kansas, Ste 1610, El Paso, TX 79901
Phone: (915) 532-2100 Ext 120