HEALTH CARE REIMBURSEMENT

			PLAN YEA	AR		
EMPLOYER			New Address Check Box:			
NAME	SOC. SEC.#					
MAILING	Your Home Number:					
ADDRESS	Your Work Number:					
To have your cla	aim processed imi	mediately for a \$	5.00 fee. Please initial box:			
	· · · · · · · · · · · · · · · · · · ·	•	self. Please print name of person picking up	p check		
and initial box:	NAME:					
MEDICAL EXPENS	E MUST BE INCURRE	DURING THE CL	JRRENT PLAN YEAR & MUST BE AN EXP	PENSETHAT		
WILL NOT BE PAI	D BY INSURANCE, A	IN ITEMIZED STAT	TEMENT FOR EACH EXPENSE MUST B	E ATTACHED.		
		MAIL TO:	HCR CLAIM			
			ZESCH & PICKETT ADMINISTRATORS	i)		
			P.O. BOX 431			
\$25.00 MINII	MUM CLAIM AMOUN	(T	SAN ANGELO, TX 76902			
		· · · · · · · · · · · · · · · · · · ·	(325) 653-1448 OR (800) 259-7302			
			FAX: (325) 655-7245 MUST SEND HARI	D COPY.		

Unreimbursed Medical Expense Claims

DATE EXPENSE INCURRED	NAME OF SERVICE PROVIDER	EXPENSE DESCRIPTION	PERSON FOR WHOM EXPENSE INCURRED	NET AMOUNT
1/1/08	Dr. John Doe	Office Visit	Jane Smith	\$50.00
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	TOTAL MEDICAL (CARE EXPENSE C	AIM	<u> </u>

TOTAL MEDICAL CARE EXPENSE CLAIM

READ CAREFULLY

The undersigned participant in the Plan certifies that all expense for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the Company's Cafeteria Plan with respect to such expense & that the medical expenses have not been reimbursed or are not responsible 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 relates to such expense.

Employee's Signature	DATE	PLAN YEAR
	FOR OFFICE USE ONLY	
BEGINNING BALANCE	DATE PAID	
CLAIM AMOUNT	PAID BY	······································
ACCOUNT BALANCE	CHECK #	<u></u>
	DATE POST	
	<u> </u>	