Unreimbursed Medical Program (URM)

REIMBURSEMENT REQUEST FORM

Employer	Plan Year **Jan 1, 2010 - Dec 31, 2010**	Daytime Phone #	
Employee's Last Name	First Name	Employee's SS#	
Employee's Address (Street)	City	State	Zip
Expenses Incurred By:	Relationship to Employee:		

_____ CHECK HERE IF NEW MAILING ADDRESS

ITEMS REQUIRED TO SUBMIT THIS FORM:

(1) Complete all pertinent information in the spaces provided, sign, date & return to Administrative Solutions, Inc.
(2) Attach an itemized statement or receipt to support requested reimbursement(s).
(3) Statement/Receipt MUST have date, expense description and amount of expense clearly listed for approval.

Date of Expense	Expense Type	Requested Amount

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form, were incurred during a period while the undersigned was covered under the Plan with respect to such expenses; and that such expenses have not been reimbursed, or are not reimbursable, under any other benefit plan coverage. The undersigned fully understands that he or she alone is 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 the payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

X_____ **X**_____
Signature Date

ADMINISTRATIVE SOLUTIONS, INC

P.O. Box 5809, Fresno, CA 93755-5809
555 W. Shaw, Suite C-1, Fresno, CA 93704
Telephone (559) 256-1320 Toll Free (866) 777-1320
Fax (559) 256-1321 Toll Free Fax (866) 333-1321

To be completed by ASI	Date Claim Received:	Approved:	Denied:	Date Posted:	Posted By: