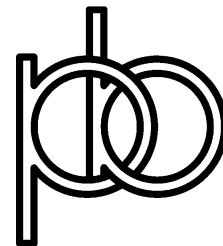


To ensure prompt processing,  
please submit completed claim  
forms, along with receipts, to:

**Kitt Craighead**  
**National Associates**  
**20325 Center Ridge Road**  
**Cleveland, OH 44116**  
**Phone: 440.333.0222, ext. 235**  
**Fax: 440.333.0221**



## Flexible Benefit Plan for UCC Ministries Medical Care Expense Claim Form

### PERSONAL INFORMATION

Social Security number	Employee's name ( <i>Last, first, middle</i> )	
Employee's home address	City/State/ZIP	E-mail address  @

As a participant in the Plan, I request reimbursement in the amounts shown below from the designated Plan year:

2009    2010

*(If additional space is needed, please use the reverse side of this sheet).*

**NOTE:** Federal law requires that you submit a written statement (such as an itemized bill from the benefit provider) as well as proof that the claim is not being reimbursed by an insurance company. Also, you will not be entitled to claim this expense as a tax deduction.

### MEDICAL CARE EXPENSE

Date Incurred	Name of Service Provider	Describe Expense	Person for Whom Expense Incurred	Net Amount
				\$
				\$
				\$
<b>Amount from reverse side</b>				\$
<b>Total amount of medical expenses</b>				\$

**READ CAREFULLY:** You are certifying that all expenses for which reimbursement or payment is claimed by submission of this form were incurred (i.e., services were provided) during a period while you were covered under the Flexible Spending Account Plan for United Church of Christ Ministries with respect to such expenses and that such expenses have not been reimbursed, or are not reimbursable, under any other health plan coverage. By signing this form, you are indicating that you fully understand that you are fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim, which is provided by the you, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, you 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. Please understand that no medical expense tax deduction or credit is permitted for amounts for which reimbursement is made.

Employee signature	Date
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For Plan Administrator use only

Payment authorized: \_\_\_\_\_

Check number: \_\_\_\_\_

Amount: \$ \_\_\_\_\_

Date: \_\_\_\_\_

