Medical-Dental-Vision Care Claim

AMERICAN MUTUAL BENEFITS
P.O.Box 1103
Cheyenne, WY 82003
ambnow.com

PLEASE PRINT **Fax to 888.884.4085** or **Email to amb@ambnow.com.** Combine receipts and photocopy on 8.5 x 11 paper.

Employee Name (first, mi, last)

Last 4 Digits of Social Security No.

Employer Name

Home Address

Email

City

State

Zip

Unreimbursed Medical Expenses

Date of Expense	Provider	Expense Description	Family Member	Amount
			TOTAL	

Employee Statement of Certification - Please read carefully and sign below.
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 the medical expenses have not been reimbursed or are not reimbursable under any other plan of coverage and that **expenses have been paid.** The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to his/her 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 Cafeteria Plan, the undersigned may be liable for payment of all related taxes including federal, state, and city income taxes and penalties on amounts paid

Employee Signature - Signature & Date *required* for claim to be processed. **Date**

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