

BURBANK EMPLOYEES RETIREE MEDICAL TRUST

Administered By: Benefit Programs Administration 1200 Wilshire Blvd., Fifth Floor, Los Angeles, CA 90017-1906 Telephone (888) 806-8944 (213) 406-2350 Facsimile (562) 463-5894

MEDICAL EXPENSE REIMBURSEMENT CLAIM FORM

Retiree Name: Street Address: City/State/Zip:			If Claim by Beneficiary, complete for Beneficiary: Name: Address:		
Phone:	aims for reimbursement:	-			
 Please submit expenses of Each submission must have bill and the address or Tale. Claims and supporting d 	covered by other medical and/or dental pave corresponding documentation such a ax ID of the service provider. Ocumentation become the property of the	plans to those plans first. as an EOB or a receipt for e Plan and <i>cannot be retu</i>	ot be assigned to the provider. Claims are processed month of a co-pay or bills showing amount and nature of expense, arned to you. If you wish to keep copies, please make then of "Covered Expenses," please refer to Sec. 1.0 of the Plan	period of time or date in	
Service Date	Provided <u>For</u> (Circle one or more)	Expense Provider	Type of Service/Coverage (Circle one)	Amount Requested	Administrator Use Only
	Name:		Medical Dental Vision Other:	\$.	
	Name: Self Spouse Dependent		Medical Dental Vision Other:	\$.	
	Name:		Medical Dental Vision Other:	\$.	
			TOTAL REQUESTED		
Service Date: When you or your service or coverage; Type of Coverage	eligible dependent received the care or serverage or Service: Please circle one; Amount F	vice; <u>Premium Period</u> : Mont <u>Requested</u> : Cannot exceed yo	h(s) covered by Premium payment; <u>Provided For</u> : Who received out-of-pocket expense after insurance payment.	d service; <u>Provider/Carrier</u>	: Who provided the ca
I certify that the above claim(and, have not been paid by and	(s) submitted for reimbursement by me other health plan. I understand that expe	to the Medical Expense I enses reimbursed through	Reimbursement Plan was incurred for services or premiur this Plan are not allowed as deductions or credits when fil	ns on behalf of me or r ing my individual incon	ny eligible depender ne tax return.
Type of documentation attach	ed:				
Participant	or Beneficiary Signature		Relationship to Retiree	Date Sig	gned