WEBER COUNTY C.O.B. REIMBURSEMENT REQUEST FORM

Employee's Name:_____Phone_____

Address: _____
Street City State Zip

Instructions: Complete the following information below for medical expenses incurred by you, your spouse or other eligible dependents and for which you request reimbursement. Please attach receipts or other evidence that the expenses were incurred. Send this form along with your supporting receipts to Personnel by the 20th of the month.

	Expense #1	Expense #2	Expense #3	Expense #4	Expense #5
Date Medical Service Actually Provided					
Name of Person Receiving Medical Service and Relation to you	__Self __Spouse __Dependent	__Self __Spouse __Dependent	__Self __Spouse __Dependent	__Self __Spouse __Dependent	__Self __Spouse __Dependent
Type of Service					
Total Expense	$	$	$	$	$

Reimbursement Requested This Page $_____

TOTAL REIMBURSEMENT REQUESTED $_____

I certify these expenses are valid medical services on the dates indicated, and have not been and are not reasonably expected to be reimbursed under this or any other health plan. I understand that these expenses may not be used to claim any Federal income tax deduction or credit.

_____ _____
Employee's Signature Date