Executive Medical Account Claim Form
For Richfield Hospitality, Inc.

Employee Last Name	First Name (please print)	Social Security Number
Patient Last Name	Patient Name (please print)	Relationship to Employee

Health Care Expenses for Reimbursement
(Medical, Dental, Orthodontia, Vision, Lasik, Rx, OTC)

Date of Service	Provider Name	Amount
___________	___________________________	________
___________	___________________________	________
___________	___________________________	________
___________	___________________________	________
___________	___________________________	________
___________	___________________________	________

Health Care Expenses Total **$**________

(Please included itemized statements and / or receipts.)

Participant Certification
(this section must be signed and dated for reimbursement requests)

I testify that I have attached records necessary to substantiate these expenses. I understand that since these expenses are reimbursed through my executive medical reimbursement account that they may not be claimed on any federal income tax deduction or credit at year end. I further certify that I will not submit these expenses for payment by a third party, such as my major medical plan, or any other health plan, such as an individual policy or my spouse's or dependent's health plan. I attest that any over the counter expenses have been incurred for the primary purpose of the alleviation or prevention of a physical or mental defect or illness and is not for cosmetic purposes and will be used by myself, spouse and/or dependents. All expenses submitted for request of reimbursement or claim substantiation are for myself and / or qualified spouse and / or qualified dependent(s) under federal guidelines.

__________ ______________________________

Date Employee Signature

Documentation Required:
Health Care Expenses: You must submit Health Plan receipts (Explanation of Benefits) sent from your health plan provider that substantiate deductibles, co-pays, co-insurance or other expenses not covered by a health plan, itemized receipts from health care providers that substantiate the date of service, type of service, cost of service and the name and phone number of the provider or itemized receipts for eligible over the counter expenses with the name of the drug or item and the date of the purchase printed on the receipt from an independent third party.

*Please note - balance forward statements, canceled checks and credit card receipts are **not** acceptable.*

Submit Claims To:
Taxsaver Plan, P.O. Box 609002, Dallas, Texas 75360
800-328-4337 TOLLFREE 214-559-0472 DFW AREA
214-528-8122 FAX
www.taxsaverplan.com