



**READ CAREFULLY**

The above-signed 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 above-signed was covered under their employer's cafeteria plan with respect to such expenses and that such expenses have not been reimbursed, or are not reimbursable, under any other health plan coverage. The above-signed fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the above-signed, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the above-signed 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. The above-signed further understands that no medical expense tax deduction is permitted for amounts for which reimbursement is made.

Claims may be sent directly to:

Employee Benefit Resources, LLP  
P.O. Box 1193  
Helena, MT 59624  
(406) 449-5500 or (800) 765-9429