HEALTH & SOCIAL SERVICE BENEFIT CLAIM FORM

I am requesting reimbursement for myself or my eligible dependents for expenses that are within the current fiscal year and were not reimbursed by any other plan, benefit program or Indian tribe. I have attached all supporting documentation of these expenses in good faith and to the best of my knowledge are eligible for reimbursement.

Name _____ ID # _____ DATE _____
Mailing Address _____ DOB _____
Phone Number Where You May Be Reached _____ Work ◯ Home ◯ Cell ◯
E-Mail Address _____ Work ◯ Home ◯
Signature _____ Address Change ◯ Phone Change ◯ E-Mail Change ◯

BENEFITS	***MEMBERS NAME***	***DATE OF SERVICE***	***AMOUNT***
UTILITIES			
City Utility			
Electric			
Firewood ***($500 MAX)***			
Natural Gas/Propane			
Trash			
Water			
DISABLED/ELDER CARE			
Auto Insurance (***One Full Coverage)***			
Lawn Mowing			
Medicare			
Main Residence Home Ins.			
Main Residence Property Tax			
Rental Property Contents Inc.			
HEALTH CARE			
Dental			
Eye Care ***(2pr. Glasses MAX)***			
Medical			
Rx			
Auditory			
Orthodontics			
Medical Equipment			
SCHOOL EXPENSES			
Clothing			
Driver Education			
Letter Jacket			
Traditional Supplies			
EXTRACURRICULAR/ENRICHMENT			
Enrichment Expenses			
BURIAL			
Burial Expenses (***$10,000 MAX)***			

TOTAL REIMBURSEMENT REQUESTED $ _____

ALL CLAIMS MUST BE SUBMITTED WITHIN 90-DAYS FROM DATE OF SERVICE & TOTAL REIMBURSEMENT REQUESTED MUST MEET THE $25 MINIMUM CHECK REQUIREMENTMAIL TO: 10100 S BLUEJACKET RD STE 1 WYANDOTTE OK 74370