MANN FINANCIAL, INC.
FLEXIBLE BENEFIT PLAN

INSURANCE PREMIUM EXPENSE CLAIM FORM

Social Security No.:_____

Participant's Name:_____
Last First Middle

The undersigned participant in the Plan requests reimbursement in the amounts shown below for insurance premiums.

Federal law requires that you submit a written statement such as the premium statement from the insurance provider. The premium statement should reflect the period of coverage, the premium amount and verification that the premium was not paid to spouse's employer. Also, you will not be entitled to claim this expense as a tax deduction.

NOTE: Policies should be pre-approved by Employer to guarantee their eligibility under Plan provisions.

INSURANCE PREMIUM EXPENSE

Period Covered	Name of Insurance	Describe Expense (Health/Life Ins.)	Person(s) Covered	Paid to Spouse's Employer (Yes/No)	Net Amount
					$
					$
					$
					$

Total amount of insurance premium expenses. $

Adequately documented claims will be processed within three working days of receipt. Claims may be sent to:

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

Complete both sides of this form and sign where indicated.

For Plan Administrator Use Only Claim Numbers _____ _____ _____ / _____

READ CAREFULLY

The undersigned 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 undersigned was covered under the **Mann Financial, Inc. Flexible Benefit Plan** with respect to such expenses and that such expenses have not been reimbursed, or are not reimbursable, under any other source. The undersigned 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 undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned 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 undersigned further understands that no tax deduction is permitted for amounts for which reimbursement is made.

_____ Date_____

Employee's Signature