MANN FINANCIAL, INC.
FLEXIBLE BENEFIT PLAN

MEDICAL CARE EXPENSE CLAIM FORM

Employee Social Security Number: _____ Daytime Phone: _____

Participant's Name:_____
Last First Middle

The undersigned participant in the Plan requests reimbursement in the amounts shown below: (If additional space is needed, please use an additional sheet.)

NOTE: Federal law requires that you **submit a written statement** (such as an itemized bill from the benefit provider) **as well as proof that the claim is not being reimbursed by an Insurance Company**. Also, you will not be entitled to claim this expense as a tax deduction.

MEDICAL CARE EXPENSES

Date Incurred	Name of Service Provider	Describe Expense	Person for Whom Expense Incurred	Net Amount
				$
				$
				$
				$
				$
				$
				$
				$

Total amount of medical expenses. $

_____(X) **CLAIM IS NOT BEING REIMBURSED BY INSURANCE**

Adequately documented claims will be processed within three working days of receipt.

_____ Date_____
Employee's Signature

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 health plan coverage. 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 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
Fax: (406) 442-5089