MGM
EDUCATOR BENEFIT PLANS
SERVING SCHOOLS SINCE 1975

Employer_____ **Claims for Reimbursement**

Participant Name_____ Social Security #_____

Email _____

Address_____ Work Phone _____

(Mailing Address) (City) (State) (Zip) Home Phone _____

☐ **Check here if new address:**

OUT-OF-POCKET EXPENSES. Attach bills, receipts or other evidence of these expenses, for expenses covered by Group Insurance Carrier, please attach an Explanation of Benefits. Canceled checks and credit card receipts are not considered sufficient documentation. Minimum check amount is $25.00.

Unreimbursed Medical Expense Claims

Date Expenses Incurred	Name of Service Provider	Expense Description	Total Expense	Amount You Paid
			Total Requested	

Dependent Care Expense Claims

Date Expenses Incurred	Service Provider - Please include Name, Address, Phone #, Tax ID# or SSN#	Expense Description & Name of Dependent	Amount You Paid
		Total Requested	

I certify that the expenses listed about have been incurred by me or an eligible dependent of mine during this Plan Year and qualify for reimbursement. I also certify that the medical expenses have not been reimbursed or are not reimburseable under any other health coverage. The paid bills, receipts and/or other evidence of these expenses are attached. I fully understand that I alone am responsible for the sufficiency, accuracy, and veracity of all information relating to this claim provided, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, I may be liable for payment of all related taxes.

_____ _____

Employee's Signature Date

Mail or Fax To:

Mass Group Marketing, Inc.
2121 N. Glenville Drive
Richardson, Texas 75082
(972) 881-2255 • (866) 881-2255
Fax # (800) 973-3702