Aurora Technical Services, LLC
engineering + construction management

Medical Expense Claim Form

Name: _____ Date: _____
Last *First* *M*

SSN: XXX - XX - _____ Employee No: _____

Submitted to: _____

The undersigned employee requests reimbursement in the amounts shown below: (if additional space is needed please use a second sheet).

NOTE: Company policy requires that you submit a written statement (such as an itemized bill(s) or receipt(s) from the benefit provider) and assurance that the claim is not being reimbursed by an Insurance Company. Further assurance may be required upon request from Human Resources.

	Date Incurred	Name of Service Provider	Purpose of Expenditure(s)	Net Amount
1.				$
2.				$
3.				$
4.				$

Total Amount of Medical Expenses $ _____

The undersigned employee certifies that all expenses for which reimbursement or payment is claimed by submission of the form, were incurred during the calendar year in which reimbursement is requested 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 responsible for the sufficiency, accuracy, and veracity of all information relateing to this claim which is provided by the undersigned. The reimbursement is to be paid through either our Health Savings Account or as a bonus via Direct Deposit. As a bonus, applicable Federal, State, and City income tax rates are applied and such taxes are withheld from the total amount of the reimbusrment. As our Health Savings Account, contributions are not taxed. In order to contribute towards the HSA, employees must be at-the-time enrolled in Aurora Technical Services Health Savings Account.

Please check one of the boxes below in which you would like your medical reimbursement/claim to be paid:

☐ **Health Savings Account**

☐ **Direct Deposit** (taxes included)

_____ _____
Employee Signature Date