EOI SERVICE COMPANY, INC.

Health Reimbursement Plan Voucher

Date: _____

Employee Name: _____

Address: _____ Social Security # - -

Federal law requires that you submit a written statement as well as proof that the claim is not being reimbursed by other coverage. Also, you will not be entitled to claim any reimbursed expenses as a tax deduction.

Medical Expense Claim(s) Reimbursement Listing

Date Expense was Incurred	Name of Service Provider	Expense Type	Person for Whom Expense Incurred	Net Amount
			Total Amount	

The undersigned participant in the Plan certifies that all expenses for which reimbursement is claimed were incurred during a period while the undersigned was covered under the 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 and accuracy of all information relating to this claim which is provided by the undersigned, and that unless an expense for which reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for the expense including federal, state or city income tax on amounts paid from the Plan which relate to such expense.

Signature:	Date:

Check Date	Check Number	Check Amount	Payment Authorized

What Benefits Are Available? The plan allows employees to be reimbursed for certain out-of-pocket medical expenses. The plan will reimburse 75% of the deductible under the High Deductible Health Plan, up to a maximum annual benefit amount of $1,600 per family or individual. If the participant has completed the ActivHealth Assessment, the eligible maximum annual benefit amount shall be $1,800. The plan will also pay annually up to $35 for physical exams.

Please fax this form to our claim administrator, PayPro Administrators at: (951) 656-9274
Questions regarding reimbursements call: (951)656-9273