

Miami Association of Firefighters Health Benefit Trust

Claim for Reimbursement – Attach Receipts to Form

E-mail: claims@div125.com
 Phone: (954) 983-9970
 Fax: (954) 983-9695

Participant Name: _____ Social Security # _____

Unreimbursed Medical Expense Claims

Date Expense Incurred	Name of Service Provider	Complete Description of Expense	Person for Whom Expense was incurred	Amount Incurred
Total Medical Care Expense				

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 Miami Firefighters Health Benefit Trust Plan with respect to such expenses and that the medical expenses have not been reimbursed or reimbursement will not be sought under any other health insurance 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 payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

Participant Signature

Date

Fax to: 954-983-9695
 E-mail: claims@div125.com
 Or mail to: Diversified Administration, Inc.
 6161 Washington Street Hollywood, Fl 33023