ROCKY MOUNTAIN COLLEGE

Retiree Health Reimbursement Plan
Medical Expense Reimbursement Application

Submit to: Rocky Mountain College, Attn: Accounts Payable
1511 Poly Drive
Eaton Hall
Billings, MT 59102
Phone: (406) 657-1012
accounts.payable@rocky.edu

Retiree name (print) _____ Phone: _____
Mailing address: _____
(for reimbursement checks)

I hereby file claim for the eligible medical expenses noted below, which qualify for reimbursement under the Rocky Mountain College Retiree Health Reimbursement Plan (the "Plan"). I certify that each expense was incurred on the date noted for myself, my eligible spouse, and/or my eligible dependent(s), who are covered by the Plan and identified on my Enrollment Form. I further certify that the amount of any expense listed below is not covered by insurance, has not been reimbursed and is not reimbursable through any other source, and that the amount of any expense listed below is not attributable to a deduction allowed under Code Section 213 for any prior taxable year. **For more information about what expenses can be reimbursed, consult the Plan's Summary Plan Description.**

Required Attachments. Documentation from a third party verifying the amount of each expense and the fact that each expense has been incurred during the applicable plan year is attached to this form (e.g., insurance premium payment receipts, doctor bills, pharmacy receipts, etc.). I understand that the administrator has the right to verify these expenses and/or request additional substantiation.

Reminder re: Deadlines and Forfeitures. I understand that I must submit a claim for reimbursement of eligible medical expenses incurred during a particular plan year during that plan year or within 90 days thereafter (i.e., by November 30). I further understand that I may forfeit unused amounts credited to my HRA Account in excess of the Plan's carry-over limit if I do not make sufficient reimbursement claims for a particular plan year.

Part I: Insurance Premiums Incurred by Myself

Date Incurred	Type of Insurance/Provider Name	(Unreimbursed) Amount
_____	_____/_____	$ _____
_____	_____/_____	$ _____

Part II: Out-of-Pocket Medical Expenses Incurred by Myself, Spouse, and/or Dependent(s)

Date Incurred	Person Treated/Relationship	Type of Service/Provider Name	(Unreimbursed) Amount
_____	_____/_____	_____/_____	$ _____
_____	_____/_____	_____/_____	$ _____
_____	_____/_____	_____/_____	$ _____
_____	_____/_____	_____/_____	$ _____
_____	_____/_____	_____/_____	$ _____
_____	_____/_____	_____/_____	$ _____

Part III: Total – Eligible Medical Expenses Claimed at This Time (add Parts I and II) $_____

I hereby authorize the above expenses to be reimbursed from my HRA Account. To the best of my knowledge, my statements on this form are true and complete.

Retiree Signature_____ Date: _____

Accepted and agreed to by the Administrator:
Administrator's Signature _____

Reimbursement Issued _____