



**RECEIPT SUBMITTAL FORM –  
TAKE CARE - DEBIT CARD**

**PART 1 – EMPLOYEE INFORMATION (Must Be Completed – Please Print)**

Employee's Name \_\_\_\_\_ Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Home Address \_\_\_\_\_ Group Name (Employer) \_\_\_\_\_  
 City/State/Zip \_\_\_\_\_ Daytime Telephone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 Check here if this is a new address  
 Take Care Card Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

**PART 2 TAKE CARE RECEIPT CLAIMS** (Attach copies of your receipts with this form (**DO NOT USE THIS FORM WHEN SUBMITTING MANUAL CLAIMS**).

For prescription drugs, documentation will include a legible copy of the original drug receipt (not the cash register tape) which includes the date of purchase, the name of the patient, the name of the drug, and the name and the address of the pharmacy from which the drug was purchased (Attach these receipts to the four boxes below. Additional receipts may be stapled to the back of this form).

For Medical, Dental and Vision expenses, documentation will include a legible copy of the doctor's itemized statement of the charges, including the date of the service, the patient's name, the name and address of the provider, a description of the services rendered, the charges for the services and the co-payment amount, if applicable (Staple these receipts to the back of this form).

**RX RECEIPT #1**

**RX RECEIPT #2**

**RX RECEIPT #3**

**RX RECEIPT #4**

NOTE: I have recently used my Health Care Reimbursement Plan debit card to pay for medical care expenses. I am submitting this form with the documentation to substantiate that such use of the card was for eligible expenses under the plan. I understand that if any part or all of such use of the card was for ineligible expenses, I will be notified and required to repay to the plan any amounts not eligible.

**PART 3 – EMPLOYEE'S SIGNATURE (Required)**

The expenses claimed above are true and correct to the best of my knowledge and belief. I agree that the Plan will have the right to recover any reimbursement made to me for any expense found to be false or otherwise ineligible for reimbursement under IRS guidelines and that I may be liable for payment of all related taxes including federal and state income tax on the amount paid from the Plan which relate to such expense. I certify that the expenses claimed have not nor will be reimbursed from any other source. I understand that any expense reimbursed under this Plan may not be claimed as a deductible expense on my federal or state income tax return.

**X** \_\_\_\_\_

Date \_\_\_\_\_