p.b. gast & sons co., inc.

Supplemental Benefit Program Reimbursement Form

EMPLOYEE NAME: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

EMPLOYEE SS#: _____

Date Incurred	Description of Expenses	Amount
		$
		$
		$
		$
		$
		$
		$
		$
		$
		$
		$
		$

Total Expenses: $

Divided by 2 = Amount to be Paid $

Are these receipts covered by any other plan of benefits?

Yes* ☐ **No** ☐

**If yes, you must attach a copy of the explanation of benefits from that covered plan.*

I certify that the statement and information on this claim form are accurate and true, to the best of my knowledge. I also certify that I am claiming reimbursement for only eligible expenses incurred during the plan year and only for eligible plan participants. I certify that these expenses have not been previously reimbursed under this or any other benefit plan. I further certify that I will not claim these, or any other expenses reimbursed through this plan, as an income tax deduction and I assume all liability for taxes and penalties arising out of any disallowed deduction/credit.

Date: _____ Employee Signature: _____

PROGRAM INCLUDES:

MEDICAL PRESCRIPTIONS
VISION CARE
ORTHONDONTIA
HEARING CARE