

**Must be attached to Main Claim Form with Member Signature**

Name: \_\_\_\_\_ UID / SSN #: \_\_\_\_\_  
 (Member's Information) (Member's Information)

Date Incurred	Name of Individual Incurring Expense	Your Out-of-Pocket Expense
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DO NOT SIGN THIS FORM - SIGN AND DATE THE MAIN CLAIM FORM AND ATTACH WITH YOUR REQUEST XXX		<b>TOTAL</b> \$