CLAIM AFFIDAVIT
REQUEST FOR REIMBURSEMENT
CITY OF _____ 401(H) PLAN

PLAN YEAR: _____ to December 31, _____

NAME: _____ SSN#_____
Please print
ADDRESS TO MAIL CHECK _____

_____

Enter eligible expenses you incurred since your last claim. Please make a copy of your receipts for your records before submitting.

Uninsured medical/dental/vision/etc. $_____

Medical premium payments $_____

Please read the following statement carefully, sign it, and attach this form to your receipts for valid medical expenses.

"I have not received nor will I receive reimbursement from any other employer-sponsored benefit plan, nor will I take any such expenses as an income tax deduction or tax credit on my personal federal income tax return. I am a retired employee of the City named above.

I certify I have examined this affidavit and to the best of my knowledge and belief it is true, correct and complete. "

Date: _____ Signature: _____

Peery & Associates, Inc. must receive claims at least 10 days prior to scheduled reimbursements at the end of each month. Please send or fax to:

Peery & Associates, Inc.
P.O. Box 850
Pescadero CA 94060

FAX: 650-879-1847

For a list of eligible expenses, please visit our website: www.ben-e-fit.com and review the 401(h) summary.