Participant Direct Reimbursement Form

Worksite Employer	9 Dig. Social Security Number

Employee Information

Employee Last Name	First Name	M.I.	Gender	Date of Birth	Day-Time Phone #
				/ /	

Employee Street Address	City	State	Zip

SUBMISSION(S) APPLIES TO:

- ☐ **Employee**
- ☐ **Employee's Spouse (fill information below)**
- ☐ **Employee's Dependent (fill information below)**

Spouse Information

Spouse's Last Name	First Name	M.I.	Gender	Date of Birth
				/ /

Name of Spouse's Employer	Spouse's Work Telephone Number	Social Security Number

Dependent Children Information

	Dependent's Last name	First Name	Relation	Number of Receipts	Total Amount Claimed
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PLEASE MAIL THIS FORM AND DETAILED RECEIPTS TO THE FOLLOWING ADDRESS:

EMI Health
Attn: A Plus Benefits, Inc. Employee Medical Plan
852 E. Arrowhead Lane
Murray, UT 84107-5298

Employee Signature and Certification of Information Accuracy

I, undersigned participant, certify that all attached expenses were incurred during a plan benefit period while I was covered under the A Plus Benefits, Inc, Employee Medical Plan. I further certify that such expenses were not reimbursed by another medical plan.

X______________________________________ ________________________

Employee Signature **Date**

Office Use Only

☐ Approved ☐ Denied	**Total Applied to EE Deductible** _________	**Total Applied to Family Deductible** _________