



Moses Cone Health System 2008 WELLNESS REIMBURSEMENT CLAIM FORM

Employee Name: _____

Employee Daytime Phone#: _____ | Employee Email Address: _____

ID#/S.S. #: _____ Employee Status: Active Terminated:

Wellness Reimbursement Request

Attach Receipt

Date Expense Incurred	Name of Service Provider/Vendor	Expense Description	Person for Whom Expense Incurred	Amount Claimed

Total Wellness Expense Claim:

I understand that claims for 2008 must be submitted by 12/31/08 and that claims submitted after my termination date will not be valid. All claims must include a dated receipt from the provider listing the services in sufficient detail to verify eligibility and documenting proof of payment. Appeals for denied reimbursements need to be made in writing within 30 days of denial to the Moses Cone Health System Wellness Committee, Human Resources, 1200 N. Elm Street, Greensboro, NC 27401.

I certify that the eligible expenses for which I am claiming reimbursement above were incurred by me for services provided to me and not other members of my family (with the exception of health club memberships where "family" memberships are eligible) and that I have not been reimbursed by any other plan for expenses claimed herein. I further certify that I have not and will not attempt to claim a deduction on my personal Income Tax Return for any expenses claimed herein.

Signature: _____ Date: _____

Form Must Be Signed For Claim to Be Paid

Mail to: Commerce Benefits Group
P.O. Box 900
Elyria, OH 44036

Phone: 800-223-9941
Fax: 440-930-7501