



Education Association Out-of Pocket Reimbursement Claim Form

*SEA Contract Only

Employee Information

Employee's Name		Date
Employee Number	Date of Birth	Employee Phone Number
Employee's Home Address		
City	State	Zip Code

Medical Provider/Service Information

Provider Name		Date of Service
Provider's Address		
City	State	Zip Code
Total Out-of Pocket Cost		

Additional Information and Instructions:

A copy of your receipts and/or a copy of your Explanation of Benefits must be attached to this form in order for the claim to be processed. Documentation must display the name of the person who received care. Failure to provide all required information may delay your reimbursement payment. Benefits will be paid directly to the employee only. No exceptions.

Reimbursement year runs July 1st through June 30th. Plan is administered on a "first come, first served" basis with an annual maximum "pool" \$10,000. Reimbursement excludes office visit co-pays for primary and specialist doctor. Dental, Vision and any services that are not a part of the medical plan will not be reimbursed (ex. Acupuncture). Dependent out of pocket expenses will be held until the end of the fiscal year and reimbursed if there are remaining funds in the pool on a "first come, first served" basis. For additional information contact 610-938-9000 ext. 2003.

Please submit claim form to:

Delaware County Intermediate Unit
Attention: Medical Reimbursement Claim- HR Benefits Office
200 Yale Avenue
Morton, PA 19070

*****DO NOT FAX CLAIM FORM*****

I hereby agree by signing this authorization that any payment made in accordance with the benefit amount of this plan shall constitute a complete release of the Delaware County Intermediate Unit (DCIU) of all liability to the extent of such payment and that I am financially responsible for charges not covered by this authorization or in excess of the benefits provided by this

Employee Signature		Date
FOR OFFICE USE ONLY		
Amount Available	Amount Approved	Date Approved
Authorized By	Date	