

ROCKWALL INDEPENDENT SCHOOL DISTRICT

**Alternate Benefit Program to Medical Insurance
(Employees with LIFE ONLY Insurance)**

EXPENSE VOUCHER

Employee's Name (please print): _____

Home Campus: _____

Social Security # _____ Date of Birth: _____

I certify that I have incurred expenses in the amounts shown below that qualify for reimbursement under the provisions of my employer's Alternate Benefit Program. I further certify that I have enclosed a copy of my current insurance **Explanation of Benefits (EOB)** form or a copy of my **HMO ID card** and receipts to substantiate the total amount below and that since these expenses are reimbursed, they must be included on my income tax filings at year end.

THESE ARE EXPENSES FOR THE YEAR OF SEPTEMBER 1, 2009 THROUGH AUGUST 31, 2010. **Deadline for submitting an Expense Voucher is October 31, 2010.** (This allows time for insurance companies to process late claims.)

Indicate below the **Total Medical Expenses** submitted. This amount is your "out-of-pocket" expenses not covered by any insurance plan. A maximum amount of **\$350** will be paid.

TOTAL AMOUNT SUBMITTED (not to exceed \$350): \$ _____ (**\$50 minimum**)

Date: _____ Employee Signature: _____

Date Approved: _____ Signature: _____

Date Sent to Third Party Administer: _____