Rockford Firefighters Relief Association, Inc.

An Illinois Not-for-Profit Corporation
204 South First Street, Rockford, IL 61104
(815) 962-5997

STATEMENT OF CLAIM

(Submit by 10th of month)

Name: ____ **Date:** ____________

Address:

____

City State: ____ **Zip:**_______________

SECTION I.

1. Medical diagnosis (Laymen Terms):____
2. Is Treatment Final: Yes / No (circle one)
3. Was this a line of duty injury or illness? Yes / No (circle one)
4. Are you covered by any other medical plans (check the appropriate selections below)

City_________ Spouse's Plan________ Medicare________ Supplemental____

Plan B FLEXCARE: ________ Other_________________________

SECTION II.

1. All payments to you are reimbursements.
2. Attach all medical expense plan worksheets, (Explanation of Benefits). Include any bills necessary to explain specific claims.
3. **IRS** regulations require that medical expenses be submitted and processed through all other plans before being submitted to FLEXCARE. **Signature:** _______ **Phone:** _____________

Your signature indicates that you have read and understand Section H.

SECTION III . (OFFICE USE)

Date Paid: ________

By: ________

Amount Claimed: $ ____________

Final Reimbursement: $ ____________

REV 2/26/04 jwc