RAYTHEON E-SYSTEMS
RETIREE MEDICAL FSA CLAIM FORM

**Retiree Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Social Security # |  |
| Address |  |
| City |  | State |  | Zip |  |
| Daytime Telephone Number |  |

**List of Expenses**

Please attach copies of bills, or other proof of expenses. Cancelled checks are not sufficient evidence. “Explanation of Benefits” (EOBs) from medical plan(s) are also required as proof of amounts not fully reimbursed by medical plan(s).

* List of eligible claims (All claims numbered to follow list)
* Billing histories for reference at end of claims section
* Further Information available upon request.

|  | Name of Retiree, Child or Dependent Receiving Service  | Relation To Retiree | Vendor | Type of Service | Service From | Service To | Amount to be Reimbursed |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 1 |  |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |  |
| 4 |  |  |  |  |  |  |  |
| 5 |  |  |  |  |  |  |  |
| 6 |  |  |  |  |  |  |  |
| 7 |  |  |  |  |  |  |  |
| 8 |  |  |  |  |  |  |  |
|  |  |  |  |  |  | Total | $0.00 |

**AUTHORIZATION**

I certify that the expenses for reimbursement requested from my Flexible Spending Account were incurred by me (and/or my spouse and/or eligible dependents), during the Plan Year and were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my Retiree Medical FSA Plan. I (or we) understand that expenses reimbursed through the Retiree Medical FSA Plan cannot also be used as deductions or credits when filing my (our) income tax return.

Employee Signature Date

**For Internal Use Only**

Amount Paid \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Paid \_\_\_\_\_\_\_\_\_\_\_\_

Account # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Approved by \_\_\_\_\_\_\_\_\_\_\_\_

**Please Return to:**

Raytheon Benefit Center

FSA Claims

PO Box 5243

Cherry Hill, NJ 08034-5243

1-800-358-1231