Employee Name_____SSN or Identifier#_____

Have you recently moved? Yes_____No_____Phone Number ( ) _____

Address_____City_____State_____Zip_____

Are you an active employee? Yes_____No_____*If No:* What was your date of termination? _____

Health Reimbursement Arrangement Payment for 2026
Claims for Reimbursement

Date Expense Incurred	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount
		***TOTAL MEDICAL EXPENSE BEING CLAIMED**		

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READ CAREFULLY

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the Company's Health Reimbursement Account Plan with respect to such expenses and that the expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expenses.

_____ _____

Employee's Signature Date

CLAIM FILING INSTRUCTIONS

1). Use this claim form for reimbursement of Medical expenses. Complete the claim form and sign where indicated.
2). Attach Explanation of Benefits (EOB) Form.
3). Send both your claim form and your documentation to Oswald Companies.

SEND THIS FORM TO:

Oswald Companies
ATTN: Steve Hopp
shopp@oswaldcompanies.com
950 Main Avenue Suite 1800
Cleveland, Ohio 44117

To qualify for reimbursement, expenses must meet the following criteria:

- **Expenses must be incurred during the 2025 Plan Year for which reimbursement is being requested.**
- **Expenses must be incurred for you and/or your IRS-eligible dependents who are enrolled in your company health care plan.**
- **Reimbursement Accounts may only be used for eligible expenses not covered by another health plan.**
- **All reimbursement claims must be submitted no later than 60 days after the end of the plan year.**

Once you submit your claim and it is approved, you will receive a check directly from DG3.