# MEDICAL EXPENSES WORKSHEET

**GROUP INSURANCE COVERAGE**

**NAME:**

**TAXATION YEAR:**

Please enter in date order

| Statement Date | Name of Insurance Company or Service Provider | Amount of Receipts Submitted or Actual Paid | Amount Reimbursed | Amount unpaid |
|---|---|---|---|---|
| ***SUBMITTED RECEIPTS*** | | | | |
| | | | | $ - |
| | | | | $ - |
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| | | | | $ - |
| ***Sub-Total of Submitted Receipts*** | | ***$ -*** | ***$ -*** | ***$ -*** |
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| ***RECEIPTS NOT SUBMITTED*** | | | | |
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| ***Sub-Total of Un-Submitted Receipts*** | | | | ***$ -*** |
| | | | | |
| ***Total Medical Expenses*** | | | | **$ -** |
| | | | | |
| | | | | |

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