ECU Human Resources, Supplemental Fringe Benefits Office
210 East 1st Street, Bldg. 127, Greenville, NC 27858
Email: gainesh19@ecu.edu or rouseti@ecu.edu | Phone: (252) 737-4801 | Fax: (252) 328-9917

Supplemental Health Expense Reimbursement Plan Agreement (SHERPA) & Dental Reimbursement Claim Form

Insured/Employee's Name _____ **Claimant's Name** _____

Relationship to Insured _____ **Claimant's Date of Birth** _____

SHERPA Claims

Medical Provider	Date of Service	Amount of Expense	Amount Eligible for Payment Under Other Benefit Plans*	Amount Eligible for Reimbursement

TOTAL: _____

*Include amounts paid or eligible for payment under any other health care plan or program, federal, state, or governmental program, workers' compensation, or any other policy of health insurance.

For all SHERPA claim submissions, please include with your claim the bill from the provider's office, the explanation of benefits from insurance, and proof of payment for the out-of-pocket expenses for each of the services listed above.

Dental Claims

Dental Office	Date of Service	Amount of Expense	Amount Eligible for Payment Under Other Benefit Plans*	Amount Eligible for Reimbursement

TOTAL: _____

*Include amounts paid or eligible for payment under any other health care plan or program, federal, state, or governmental program, workers' compensation, or any other policy of health insurance.

For all dental claim submissions, please include with your claim the bill from the provider's office listing services received, the explanation of benefits from the dental insurance company (if enrolled), and proof of payment for the out-of-pocket expenses for each of the services listed above.

Important Notice: Services paid with Healthcare Flexible Spending Account funds are ineligible for reimbursement. A person may be committing insurance fraud if he or she submits a claim containing a false or deceptive statement with intent to defraud an insurance company.

I certify the information provided above is correct. If any changes occur after submission of a claim, it is my responsibility to notify the Supplemental Fringe Benefits Office of such changes immediately.

_____ _____

Insured/Employee's Signature **Date**