Claim for Annual Physical or Hospital Income

Date Submitted: _		
Employee Name: _		
Employee Address: _		
Employee Phone:		
Employee Work Site:		
This claim is for:	Annual Physical	
	Hospital Income	
to the district's benef	_Complete this form and return it with a copfits specialist. Please make sure it shows the formed (billing should state you had a physical-320-9042-7104)	date of service, physician's name (or
•	Complete this form and attach a copy of the arge dates and return this form to the district -7104)	•
Send Completed form	n to: Chris Olson, Coordinator of Employee S	ervices
	Superintendent of Schools Office Administrative Complex	
	(850) 838-2500	
Approval for paymen	t by Benefit's Specialist:	
	(Signature of Benefi	t's Specialist)
Date of Approval for	payment by Benefit's Specialist:	
Dollar Amount Appro	oved for payment by Benefit's Specialist:	
<u>Please note:</u> This form see Keith Johnson about	m is for annual physical or hospital income of out your claim.	nly. If you are a bus driver, you should
Your claim must be fi	led within 12 months. After 12 months, you	will be unable to claim and/or receive

reimbursement.