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				
Sub-Total of Submitted Receipts				
RECEIPTS NOT SUBMITTED				
Sub-Total of Un-Submitted Receipts				
Total Medical Expenses				

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