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CERTIFICATION FOR HEALTHCARE EXPENSE REIMBURSEMENT

By signing this form, I hereby certify that:

- 1) I, my spouse, or my eligible dependent(s) has incurred each health care coverage premium expense for which I am requesting reimbursement from the East Bay Regional Park District Health Reimbursement Arrangement (EBRPD HRA) on this form;
- 2) each such expense is eligible for reimbursement under the EBRPD HRA;
- 3) each such expense has not been reimbursed from any other source, including another health reimbursement arrangement;
- 4) I will not seek reimbursement for the expense(s) from any other source; and
- 5) to the best of my knowledge and belief, each of my statements in this form is true, complete, and accurate.

Expenses for Which Reimbursement is Requested (please attach proof of payment):

Printed Name

Date

Signature

Board of Directors

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