RAYTHEON E-SYSTEMS
RETIREE MEDICAL FSA CLAIM FORM

Retiree Information

Name ________________________________ Social Security #: ______--_ __ _--_______

Address ____

____

City _________________________________ State Zip ___________

Daytime Telephone Number (_____) _______-- ______________
Area Code

List of Expenses

Please attach copies of bills, or other proof of expenses. Cancelled checks are not sufficient evidence. "Explanation of Benefits" (EOBs) from medical plan(s) are also required as proof of amounts not fully reimbursed by medical plan(s).

Name of Retiree Child or Dependent Receiving Service	Relationship To Retiree	Types of Service	Dates of Service From	To	Amount to be Reimbursed

AUTHORIZATION

I certify that the expenses for reimbursement requested from my Flexible Spending Account were incurred by me (and/or my spouse and/or eligible dependents), during the Plan Year and were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my Retiree Medical FSA Plan. I (or we) understand that expenses reimbursed through the Retiree Medical FSA Plan cannot also be used as deductions or credits when filing my (our) income tax return.

Employee Signature ____ Date ______________

Please Return to:	For Internal Use Only
Raytheon Benefit Center – FSA Claims PO Box 5243 Cherry Hill, NJ 08034-5243 1-800-358-1231	Amount Paid _________________ Date Paid _________________ Account # ___________________ Approved by ______________