StaffScapes, Inc.

REQUEST FOR REIMBURSEMENT UNDER THE MEDICAL EXPENSE REIMBURSEMENT PLAN

The following information is provided regarding the expenses, which I would like to have reimbursed to me under the Medical Expense Reimbursement Plan. Attached are receipts, bills, cancelled checks, vouchers, or other proof, which verify these expenses. [Note: If more than one medical expense has been incurred, please submit forms for each medical expense for which reimbursement is requested.]

Please note that before reimbursement of a medical expense may be obtained under this plan, a request for reimbursement must first be sought under the Company's insured medical plan. Also, a copy of the certificate from the insurance company, in response to the request for reimbursement, must be attached to this form.

My Name: _____

Nature of Medical Expense: _____

_____

Services performed at _____

by: _____

*on (date)*_____

Amount of Medical Expense: *$* _____

Amount Reimbursed under Company's Insured Medical Plan: *$* _____

Net Unreimbursed Amount: *$* _____

I hereby state the expenses described above are true and valid and are not reimbursable by any other medical plan or insurance policy.

_____ _____

Signature of Participant *Date*