

PRESCRIPTIONS

BENEFIT REQUEST

Branch Location: _____ Date of Request: _____

Your Name: _____ Classification: _____

I am requesting payment/reimbursement for the following benefit:

Continuing Education Benefit

Health Insurance Subsidy

Other _____

I am requesting payment/reimbursement for the above listed benefit. I have read the requirements of the benefit that I am requesting in the Prescriptions Program Summary, and fully understand and agree to comply with the requirements as indicated. I have submitted all required documentation for this benefit. I further understand that this request will be reviewed by the local Branch office of BrightMed and must be approved by both the Division Vice President and the National Service Center. Once approved I will receive the bonus/reimbursement amounts listed in accordance with company policy. I agree to adhere to all terms of the Prescriptions program and have made this request in good faith and within the time allotted for this benefit.

Employee Signature

Branch/National Service Center Use Only

Request made within the terms of the Prescription Program

All documentation has been submitted with this request and forwarded to the N.S.C.

Branch Director Approval

President Approval