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Section 125 Flexible Benefits Plan – Reimbursement Claim Form

Plan Year Ending:		Employer:						
Name:				Last Four Digits of SSN:				
Address:						- 1 00 - 1		
Dependent Care	Reimburs	sement C	laim					
Name and Age of Dependent		Date Inco	urred	Name of Provider/Tax ID or SSN				Amount Incurred
Attach a receipt from your daycare provide			r.	Total Dependent Care Expense Claim				
Health Care Rei	mburseme	ent Claim	L					
Provider Name	Date Incurred	Office Visit	RX	Dental	Vision	OTC Drugs	Orthodontics	Amount Incurred
		0	0	0	0	0	0	
		0	0	0	0	0	0	
		0	0	0	0	0	0	
		0	0	0	0	0	0	
Attach appropriate receipts.			Total Health Care Expense Claim					
Group-Term Li	fe Insuran	ce Premi	ums I	ncurrec	i to Date	e: \$		
Outside Health	Insurance	Premiun	ns Inc	urred to	Date:	\$		-
Health: \$ Dental: \$_					Disa	ability: \$		
Optical: \$		Othe	r: \$					
The undersigned participant in while the undersigned was conbe presented for reimburseme accuracy and veracity of all in claimed is a proper expense up the Plan which relate to such e	vered under the Co nt through any oth nformation relating nder the Plan, the u	ompany's Cafeter ner health covera g to this claim w andersigned may	ria Plan wit ge plan. T hich is pro be liable fo	th respect to s The undersign wided by the or payment of	uch expenses a ed fully unders undersigned, a all related taxe	nd that the med stands that he co nd that unless a se including fed	dical expenses have n or she alone is fully r an expense for which leral, state, or city inc	ot been reimbursed or will not esponsible for the sufficiency, payment or reimbursement is ome tax on amounts paid from
Signature					Date			