

SECTION 125 CAFETERIA PLAN CLAIM FORM

EMPLOYER/COMPANY NAME: _____ DATE: _____
 EMPLOYEE NAME: _____
 DAYTIME PHONE: _____ EMPLOYEE SSN#: _____
 EMPLOYEE EMAIL ADDRESS: _____

Flexible Spending Account - Medical Expenses

The attached charges are to be considered for reimbursement under Section 125 benefit program. I certify that these expenses or services have been incurred during the plan year for which I am filing. These charges have been added and the total entered on the line below: (Please do not say "See Attached"...a list must be made.)

Date Incurred	Person Treated	Nature of Expense	Amount Of Expense
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
TOTAL MEDICAL EXPENSES CLAIMED			\$ _____

Flexible Spending Account - Dependent Care Expenses

The attached charges are to be considered for reimbursement under Section 125 benefit program. I certify that these expenses or services have been incurred during the plan year for which I am filing. These charges have been added and the total entered on the line below:

Date Incurred	Person Cared For:	Amount Of Expense	Provider Name, Address & Tax I.D. # (Required)
_____	_____	\$ _____	_____
_____	_____	\$ _____	_____
_____	_____	\$ _____	_____
_____	_____	\$ _____	_____
_____	_____	\$ _____	_____
_____	_____	\$ _____	_____
_____	_____	\$ _____	_____
_____	_____	\$ _____	_____
TOTAL DEPENDENT CARE EXPENSES CLAIMED			\$ _____

EMPLOYEE CERTIFICATION: I certify that either I or my dependents have incurred the expenses claimed above. I, my dependents or the providers of the services claimed have not received, nor will receive reimbursement for any claimed expenses from any insurance carrier or other third party. I have not received reimbursement previously for these expenses from my Flexible Spending Account (s) or any other plan. I understand that neither I, nor my dependents, may deduct these expenses on an individual federal income tax return.

 Employee Signature

NOTE: All expenses must be **INCURRED** during the plan year, regardless of when billed or paid. Attached receipts or documentation must show dates of service. Copies of checks, statements of payments, credit card receipts, etc. cannot be accepted. Checks will not be issued for less than \$5.00 other than at the end of a plan year.