CAFETERIA PLAN/FLEXIBLE SPENDING PLAN
CLAIM FOR REIMBURSEMENT

EMPLOYER/LOCATION_____

EMPLOYEE NAME_____

EMPLOYEE ADDRESS_____

EMPLOYEE SOCIAL SECURITY NUMBER_____ HOME PHONE_____

WORK PHONE_____

SECTION I: DEPENDENT CARE EXPENSE CLAIMS

NAME OF DEPENDENT(S)	PERIOD COVERED From	To	Receipts must be attached	AMOUNT INCURRED
			Name, address and taxpayer ID number of provider of service:	
Total Amount Being Requested				$

SECTION II: UNREIMBURSED MEDICAL EXPENSE CLAIMS (for self, spouse or dependents)

DATE SERVICE PROVIDED	NAME OF SERVICE PROVIDER Receipts must be attached	SERVICE DESCRIPTION	NAME OF PATIENT	AMOUNT BEING CLAIMED
	Total Amount of Request			$

The undersigned participant in the Cafeteria Plan certifies that all expenses for which reimbursement is claimed by submission of this form, were incurred during a period while the undersigned was covered under the Plan with respect to such expenses, and that these expenses have not previously been reimbursed and are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim, and that unless an expense for which reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for the payment of all taxes on amounts paid from the Plan which relate to such expenses. The undersigned also understands that he or she is responsible to keep sufficient documentation to substantiate the expenses claimed for reimbursements, as may be required by the IRS.

_____ _____

Employee's Signature Date