SECTION 125 CAFETERIA PLAN
MEDICAL CARE EXPENSE CLAIM FORM

***A valid photo ID must be attached to this request.***

Plan Name: _____Participant's Name:_____

Social Security No.: _____ Contact No.: _____

The undersigned participant requests reimbursement in the amounts shown below: (If additional space is needed please use the attached sheet.)

**NOTE:** Federal law requires that you submit a written statement such as copies of the receipts. The receipt must show the patient's name, service provider, date, and type of service for the expense. Cancelled checks, credit card slips or statements showing only a balance due on your account are **not** valid receipts. You must certify that the claim is not being reimbursed by an Insurance Company. Also, you will not be entitled to claim this expense as a tax deduction.

| Date Incurred | Name of Service Provider | Describe Expense | Person for Whom Expense Incurred | Net Amount |
|---|---|---|---|---|
| _____ | _____ | _____ | _____ | $ _____ |
| _____ | _____ | _____ | _____ | $ _____ |
| _____ | _____ | _____ | _____ | $ _____ |
| | | | Amount from attached Form | $ _____ |
| | | | Total amount of Medical Expenses | $ _____ |

**PLEASE READ CAREFULLY**

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form, were incurred (i.e., services were provided) during a period while the undersigned was covered under the SECTION 125 CAFETERIA PLAN with respect to such expenses and that such expenses have not been reimbursed, or 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 which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the law, the undersigned may be liable for the payment of all related taxes including federal, state or local income tax on amounts paid from the Plan which relate to such expense. The undersigned further understands that no medical expense tax deduction or credit is permitted for amounts for which reimbursement is made.

_____ _____

Employee's signature Date


# MEDICAL CARE EXPENSE CLAIM FORM (CONTINUED)

Participant's Name: _____ Date: _____
Last First Middle

| Date Incurred (not date billed) | Name of Service Provider | Describe Expense | Person for Whom Expense Incurred | Net Amount |
|---|---|---|---|---|
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |

**Total (enter here and on front of form)** $_____