SECTION 125 CAFETERIA PLAN
MEDICAL CARE EXPENSE CLAIM FORM

General Information

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

Employer / Plan Name

Your Name (Last Name, First Name, Middle Initial) | Social Security Number | Contact Number

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 _____

Request for a Direct Payment to You

The total amount claimed will be paid via ACH (Direct Deposit) only.

ATTACH A VOIDED CHECK OR BANK STATEMENT

I have attached a voided check or bank certification that contains the valid routing number and bank account number. I have also provided my physical address as required by the bank.

YOUR PHYSICAL ADDRESS: _____

BANK NAME: _____

Savings Account Number: _____ Routing Number: _____

Checking Account Number: _____ Routing Number: _____

By completing this section and signing below, I hereby authorize ASC TRUST LLC **1.**) to initiate credit entries to the depository financial institution named above **2.**) to initiate debit entries to adjust for processing errors. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law.

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.

X _____

Signature of Participant | Date

SECTION 125 CAFETERIA PLAN
MEDICAL CARE EXPENSE CLAIM FORM

(Continued)

Your Name (Last Name, First Name, Middle Initial) _____ Date _____

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) $_____