

**Claim for Reimbursement**  
**Fax # 800-421-6737**

Employer \_\_\_\_\_

Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Daytime Phone # \_\_\_\_\_

**Daycare Expense Claims**

Daycare requires a receipt from the child care provider OR a copy of a check issued for payment

Name of Dependent(s)	Period From	Covered To	Name & Address of Service Provider	Amount Incurred

<b>TOTAL DAYCARE EXPENSE CLAIM</b>	
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**Employee Owned Private Health Insurance Expenditure**

Employee owned private Health Insurance requires proof of payment or a current bill/statement showing coverage period and amount

Date of Coverage	Name and # of Insurance Policy	Employee Policy Holder Name	Net amount

**Unreimbursed Medical Expense Claims**

Unreimbursed medical requires a copy of an Explanation of Benefits from the insurance company or bill from the provider showing date of service and what you owe after insurance has paid.

Date of Service	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount

<b>TOTAL MEDICAL CARE EXPENSE CLAIM</b>	
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**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 during a period while the undersigned was covered under the Company's Cafeteria Plan with respect to such expenses. 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 plan, the undersigned may be liable for payment of all related taxes including federal, state or city income tax on amounts paid from the plan which relate to such expense. The undersigned also states that he or she will not receive reimbursement for the above charges from any other source.

Employee's Signature \_\_\_\_\_

Date \_\_\_\_\_