Employer Educational Service Unit #2

Claim for Reimbursement
Fax # 800-421-6737

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
			TOTAL DAYCARE EXPENSE CLAIM	$ 0.00

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
			TOTAL MEDICAL CARE EXPENSE CLAIM	$ 0.00

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.

_____ _____

08/2007 Employee's Signature Date