

If Faxing
of Pages



EMPLOYEE INFORMATION (Please Print)

Check here if address has changed

Name: _____
 Address: _____
 City, State, Zip: _____

SSN: _____
 Email : _____
 Day Phone: _____

UNREIMBURSED HEALTHCARE EXPENSES (Attach supporting documentation)

Do your receipts include <u>all</u> of the following?	Provider's Name & Address Patient's Name Date of Service	Service Provided Amount billed	*** Credit card receipts are not acceptable ***	
Person for Whom Expense was Incurred	Date of Service	Name of Service Provider	Description of Services	Amount
Total Unreimbursed Healthcare Expenses				

DEPENDENT DAYCARE EXPENSES (Attach supporting documentation if Provider does not sign form)

Supporting documentation for dependent care expenses is required only if provider does not sign this form. Otherwise, documentation must include the provider's name, address, Tax I.D.#, dependent's name, service description, dates of service and amount charged.

Child's Name	Age	Service Date		Name & Address of Service Provider	Amount
		From	To		
Total Dependent Care Expenses					

I certify that I have provided dependent care services as described above. I have charged \$_____ for the services I rendered on the dates listed above.

Provider Social Security # or Taxpayer ID # _____ Signature of Dependent Care Provider _____

READ CAREFULLY

The above is a true and accurate statement of all expenses incurred by my eligible dependents or me on the date(s) indicated, and I will not seek reimbursement from any other plan including a Health Savings Account (HSA). I understand that I cannot claim any reimbursed expenses on my income tax return, and that I may be liable for payment of all related taxes including Federal, State, or City income tax and any associated penalties on the amounts paid for any expense improperly claimed under the provisions of this plan.

Participant Signature

Date

Access your account information 24 hours a day, seven days a week on our web site: www.myCafeteriaPlan.com