If Faxing
# of Pages

EMPLOYEE INFORMATION *(Please Print)*

Check here if address has changed

Name: ______________________ SSN: ______________________

Address: ______________________ Email : ______________________

City, State, Zip: ______________________ Day Phone: ______________________

INDIVIDUAL INSURANCE PREMIUM REIMBURSEMENT *(Attach supporting documentation)*

Does your receipt include all of the following? Insurance Carrier's Name and Address; Employee's Name; Dates of Coverage; Amount Charged

Employee's Name and any covered dependent(s)	Date of Coverage		Insurance Carrier Name	Amount
	From	To		
		Total Individual Premium Expenses		

READ CAREFULLY

The above is a true and accurate statement of all expenses incurred by my eligible dependents and me on the date(s) indicated, and were incurred while I was covered under the Premium Reimbursement Account(s). Supporting documentation from my service provider(s) for all expenses are attached to this voucher. 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 the Premium Reimbursement Account(s).

______________________ Participant Signature ______________________ Date

Mail To: myCafeteriaPlan, 432 East Pearl St., Miamisburg, OH 45342
Fax To: 937.865.6502 **Email To**: claims@myCafeteriaPlan.com
To contact Customer Service call 800.865.6543

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

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