

Section 125 Cafeteria Plan Reimbursement Request form



Employee Name

Employee Social Security Number

Months Covered

PLEASE ATTACH RECEIPTS

Section One : Medical / Dental Expenses

* Include insurance premiums you paid directly to insurance companies. Give us details as to whom, when, why the expense was incurred.

Whom - (Yourself, Spouse, Dependent)	Were / Date - (Dr office, Jan 1, XXXX)	What - (Cut finger, exam, sickness)	Amount Requested

Section Two : Dependet Care Expenses

* Include age of child or disabled adult, where the service was performed and to whom the money was paid to.

Whom - (Name & Age)	Date(s) of Service - (Jan 1-15, XXXX)	Were (Home, Center)	Whom paid	Amount Requested

www.CentsSolutions.com / Fax 435.753.4039 / Phone 435.787.2828

*** Reimbursements will not occur until such reimbursement equals \$15.00 or more, unless last quarter of the year.**

TO THE BEST OF MY KNOWLEDGE AND BELIEF, MY STATEMENTS IN THIS REIMBURSEMENT REQUEST FORM ARE COMPLETE AND TRUE. I AM CLAIMING REIMBURSEMENT ONLY FOR ELIGIBLE EXPENSES INCURRED DURING THE APPLICABLE PLAN YEAR. I CERTIFY THAT THESE EXPENSES HAVE NOT BEEN PREVIOUSLY REIMBURSED UNDER THIS OR ANY OTHER BENEFIT PLAN AND WILL NOT BE CLAIMED AS AN INCOME TAX DEDUCTION.

Date

Signature