



YOUR SECTION 125 PLAN SERVICE SPECIALISTS

**EMPLOYEE INFORMATION** (Please Print)

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_

Check here if address has changed   
 SSN: \_\_\_\_\_  
 Day Phone: \_\_\_\_\_  
 Employer: \_\_\_\_\_

**UNREIMBURSED MEDICAL 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	<b>*** Credit card receipts are not acceptable ***</b>	
Person for Whom Expense was Incurred	Date of Service	Name of Service Provider	Description of Services	Amount
<b>Total Unreimbursed Medical Expenses</b>				

**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, dates of service and amount charged.**

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

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 were incurred while I was covered under the Flexible Spending 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 Flexible Spending 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](http://www.myCafeteriaPlan.com)**