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MEDICAL/DENTAL REIMBURSEMENT
CHILD CARE REIMBURSEMENT

For the plan year listed below only Medical/Dental Reimbursement expenses INCURRED during this time will be eligible to be sheltered in the Cafeteria Plan. In order for the reimbursement system to work properly and there be no delay in your receiving reimbursement for expenses, it is necessary that your receipt for expenses be received in our office no later than the 15th of each month. WE ARE NOT RESPONSIBLE FOR MAIL DELAYS. For example, for you to be promptly reimbursed for your October Medical/Dental Reimbursement expenses, you must have your receipts for expenses turned in by October 15, then you will receive any amount to be reimbursed by the end of the month.

PLEASE NOTE: A RECEIPT FOR SERVICES PERFORMED DURING THE PLAN YEAR MUST ACCOMPANY YOUR SIGNED VOUCHER. THE BILLS MUST FIRST BE SUBMITTED TO YOUR MEDICAL OR DENTAL INSURANCE COMPANY FOR PAYMENT, A COPY OF THE EXPLANATION OF BENEFITS SHOULD BE SENT IN WITH YOUR RECEIPT. IF YOU DO NOT HAVE MEDICAL OR DENTAL INSURANCE YOU MUST SUBMIT AN ITEMIZED BILL FROM THE FACILITY PROVIDING THE SERVICES. THIS ITEMIZED BILL MUST HAVE THE NAME & ADDRESS OF THE FACILITY, AMOUNT CHARGED, DATES OF SERVICE, NAME OF PERSON TREATED. COPIES OF CHECKS WILL NOT BE ACCEPTED.

Should your receipt not arrive by the above time, you will be reimbursed the next month after your receipt is turned in.

Also, be cautious in how much expense you estimate for the Cafeteria Plan year. Should you estimate more expense for the plan year than you actually experience, the LAW WILL NOT allow your employer to refund the extra money. You would lose it!

Receipts are due in our office NOT LATER THAN the 15th of the month.

Please feel free to contact our office if you have any questions.

RECEIPT ACKNOWLEDGED THIS _____ DAY OF _________________, ________.

ALL INFORMATION BELOW MUST BE COMPLETED: INCOMPLETE FORMS WILL BE RETURNED.

PRINT NAME: ______________________________

ADDRESS: ____________________ CITY ____________________ ZIP ____________

SOCIAL SECURITY # ____________________ HOME PHONE ____________________

EMPLOYER: ____________________ LOCATION: ____________________

CAFETERIA PLAN YEAR: ______________________________

ANNUAL EXPENSES: ____________________ MONTHLY DEDUCTION: ____________________

SIGNATURE ______________________________