

Medical & Dependent Care Expense Reimbursement Request Form

PLEASE PRINT CLEARLY, USE ALL CAPITAL LETTERS

Employer: _____

Soc. Sec. #: _____ **Name:** _____

Address: _____

City/State/ZIP: _____ **Phone:** _____

INSTRUCTIONS

Complete the information below for medical and dependent care expenses incurred by you, your spouse, or other eligible dependents and for which you request reimbursement. **You must attach itemized bills that include patient name, date and description of service, fees charged, and the name and address of the provider. Cancelled checks and plain receipts are not acceptable.** To help insure timely and accurate processing of this claim, please provide all the information requested by this form. **If the form is incomplete, it must be returned to you.** Please print or type the information requested, then sign and date the form. Send or fax this form, along with your supporting information to:

The Benefit Companies
Cafeteria Claims
2696 South Colorado Boulevard
Suite 304
Denver, CO 80222

Fax: (303) 226-1010
Phone: (303) 226-1000
(800) 530-2211

	Expense #1	Expense #2	Expense #3
Date of treatment or service:	_____	_____	_____
Name of recipient of treatment/care:	_____	_____	_____
Relationship to employee: (circle one)	Self / Spouse / Dependent	Self / Spouse / Dependent	Self / Spouse / Dependent
Type of Service: (circle one)	Medical / Dependent Care	Medical / Dependent Care	Medical / Dependent Care
Total cost of expenses:	\$ _____	\$ _____	\$ _____
Amount paid by other plans:	\$ _____	\$ _____	\$ _____
Amount requested:	\$ _____	\$ _____	\$ _____
Total reimbursement amount requested:	\$ _____		

Remember to attach the itemized information listed in the Instructions Section or the claim form must be returned to you.

IMPORTANT NOTE: For reimbursement of Dependent Care Expenses, the IRS requires that you provide the following information regarding The Dependent Care Provider:

Provider Name: _____ Federal Tax ID or Soc. Sec.#: _____

Address: _____

To the best of my knowledge and belief, my statements in this Reimbursement Request are complete and true. I certify that these expenses are for valid medical and dependent care services provided on the dates indicated and have not been and are not reasonably expected to be reimbursed under any other plan. I understand that these expenses may not be used to claim any Federal income tax deduction or credit.

Employee Signature

Date

