PAPER CLAIM Reimbursement

Employer: _____ Your e-mail address: _____

Name: _____ Last 4 SSN #: _____ Daytime Ph. #: _____

E-mail your claim with copies of your EOB's & receipts to: Support@cps125.com
OR
Fax your claim with copies of your EOB's & receipts to: 772.334.7059

Dependent Care (Daycare) Expense Claims Authorization

Name of Dependent(s)	Period Covered From	Period Covered To	Name, Address, and Taxpayer Identification Number (or SSN) of Daycare provider	Amount Incurred
				$
			*Total Dependent Care Expense Claim	$ 0

* Note: the total amount claimed under the Plan for any coverage period must not exceed the lesser of your earned income for the plan year or the earned income of your spouse. (If your spouse is either a full-time student or is incapable of taking care of himself or herself, then he or she is deemed to have monthly earnings of $250 if there is one (1) child or dependent, and $500 if there are two (2) or more.) No payment may be made under the Plan if the service provider is your dependent for federal income tax purposes, or is your child or stepchild and is under age 19.

Unreimbursed Medical/Rx/Dental/Vision Expense Claims

Date Expense Incurred	Name of Service Provider (Please attach EOB's if you have insurance)	Type of Expense (Medical, Rx, etc.)	EOB Attached? (Required if you have insurance!)	Reimbursement Amount
				$ 5
				$ 5
				$ 5
				$ 5
				$ 5
				$ 5
				$ 5
				$ 5
		Total Reimbursement Amount:		$ 40

Read Carefully

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the Company's Cafeteria Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

X_____ X_____
Employee's Signature Date

QUESTIONS? E-mail us at: Support@cps125.com or call us at 772.334.3995