Educators Benefit Consultants, LLC
Third Party Administrator

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Section 125 Flexible Benefits Plan – Reimbursement Claim Form

Plan Year Ending: _____ **Employer:** _____

Name: _____ **Last Four Digits of SSN:** _____

Address: _____

Dependent Care Reimbursement Claim

Name and Age of Dependent	Date Incurred	Name of Provider/Tax ID or SSN	Amount Incurred
Attach a receipt from your daycare provider.		**Total Dependent Care Expense Claim**	

Health Care Reimbursement Claim

Provider Name	Date Incurred	Office Visit	RX	Dental	Vision	OTC Drugs	Orthodontics	Amount Incurred
		O	O	O	O	O	O	
		O	O	O	O	O	O	
		O	O	O	O	O	O	
		O	O	O	O	O	O	
Attach appropriate receipts.				**Total Health Care Expense Claim**				

Group-Term Life Insurance Premiums Incurred to Date: $_____

Outside Health Insurance Premiums Incurred to Date: $_____

Health: $_____ **Dental: $**_____ **Disability: $**_____

Optical: $_____ **Other: $**_____

The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided 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 will not be presented for reimbursement through any other health coverage plan. 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. I declare that the information I have furnished above is, to the best of my knowledge and belief, true, correct and complete.

_____ Signature

_____ Date