BUD MAHAS CONSTRUCTION INC

Cafeteria Plan
Request for Reimbursement
CLAIM FORM

COMPANY		Dept	
NAME:		SS#:	

Please read the Reimbursement Account Rules and Claim Filing Instructions before completing this claim.

*** Information below must be completed**

MEDICAL EXPENSE CLAIMS

Date of Service	Patient Name	Patient's SS#	Relationship	Name of Provider	Description of Service	Claim Amount
						$
						$
						$
						$
						$
						$
						$
						$
						$

DEPENDENT CARE CLAIMS

Date of Service From	To	Dependent Name	Age	Dependent Care Provider Name	Dependent Care Provider Address	Provider Tax Id#/SS#	Claim Amount
							$
							$
							$
							$
						Total:	$

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature: _____ **Date:** _____ /_____ /_____

Fax Request to: 801-521-8780 or email to: lewis@wasatchbenefit.com or mail to:

Wasatch Employee Benefit Service, Inc. / P.O. Box 510566, Salt Lake City, Utah 84151-0566