Health Plan Alternatives Agency, Inc.
P.O. Box 884
Westerville, Ohio 43081
(800) 898-8262 (614) 890-8262

Reimbursement Request Form for Section 125 Cafeteria Plan

(Please print)

Participant's Name: _____

Place of Employment: Fairfield County, Ohio

Social Security Number: _____

Medical Care Expense (please use back of form if additional space is needed)

Date of Service	Service Provider	Description of Service	Person Receiving Service	Net Amount
				$
				$
				$
				$
				$
				$
				$
				$
				$

Total Medical Expenses from reverse side $ _____

Total Medical Expenses **$** _____

Child Care. If you are having reductions made for childcare but are not receiving automatic reimbursements on your pay dates, you may also use this form for your childcare reimbursement requests.

In order to process a request for reimbursement, we must have a statement of services rendered along with proof of payment. Please attach an itemized bill showing date of service, patient's name, services rendered, and payment for each expense listed above. A cancelled check, along with the itemized bill, is acceptable also.

Certification. I certify that I am claiming reimbursement for eligible expenses only and that these expenses have not been previously reimbursed under this or any other benefit plan. I certify that these expenses were incurred during an applicable plan year and that they were incurred for eligible plan participants. I understand these expenses will no longer qualify as tax deductions or credits.

Employee's Signature: _____ **Date:** _____