



Professional Benefit Services, Inc.
Affordable administration of employee benefit plans

CLAIM FORM CAFETERIA PLAN

EMPLOYER: _____

Participant Name:			Employee ID: (last 4 SSN)
Mailing Address:		<input type="checkbox"/> Check box if this is a change	Phone Number:
City:	State:	Zip:	Email Address:

SECTION 125 REIMBURSEMENT EXPENSES

Unreimbursed Health Care Expense (FSA)

\$

Dependent Daycare Expense (DCA)

\$

Other Insurance Premium (Individually owned policy)

\$

This is to certify that I have incurred expenses in the amounts shown above that qualify for reimbursement under the provisions of my employer's Section 125 Cafeteria Plan.

I am attaching copies of documentation from my service provider that shows date(s) and type(s) of service (i.e., a bill or receipt from the Doctor, hospital, lab, pharmacy, day care provider, etc.). I certify that these expenses have been incurred and have not been reimbursed, or are not reimbursable, under any other health plan coverage. Since these expenses are being reimbursed by my employer, they may not be claimed on my income tax filings at year end. I understand that it is my responsibility to inform PBS of any address change.

To view your balance and transaction history, please visit www.benefitspaymentsystem.com.

Participant Signature: _____ Date submitted: _____

***As of 01/01/2011 over the counter products will no longer be eligible for reimbursement through a cafeteria plan unless accompanied by a doctor's prescription. Please call with any questions.

Send claims to: Professional Benefit Services, Inc.
1193 Royvonne S.E., Suite 22 Salem, Oregon 97302
 Phone: (800)982-2012, (503)371-7622 Fax: (503)364-6901, (866)248-9742
 Email: cafeteria@profben.com Website: www.profben.com