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

CLAIM FORM
CAFETERIA PLAN

Employer:		
Participant Name:		***Employee ID: (SSN)***
Mailing Address:	❑ ***Check box if this is a change***	***Phone Number:***
City: ***State:*** ***Zip:***		***Email Address:***

SECTION 125 REIMBURSEMENT EXPENSES

Health Care/Flexible Spending Expense (FSA)	$
Dependent Daycare Expense (DCA)	$
Other Insurance Premium (Individually owned Supplemental 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 by myself or my tax dependent 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 https://www.mywealthcareonline.com/pbsfsa

Participant Signature: _____Date submitted: _____

****Download the new claim submission app and submit your claims from your smartphone. Available for android and iphone.*

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