PAYROLL MANAGEMENT, INC.

Cafeteria Plan CLAIM FORM

PLAN YEAR :

NAME OF EMPLOYER:_____ CLT #_____

Flexible Spending Arrangement:

[ ] Health Care Reimbursement Claim(s) Total: $_____

[ ] Child Care Reimbursement Claim(s) Total: $_____

EMPLOYEE NAME:_____ SS#_____

Claims are for: [ ] Self [ ] Dependent(s) Name:_____
Name:_____

Reimbursements are paid specifically to reimburse the participant for health care expenses as outlined in the plan brochure or dependent care expenses as qualified in the plan brochure incurred during the period of coverage. I agree to notify my employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the employer, on demand, for any liability it may incur for failure to withhold Federal, State, or local income tax or FICA tax from any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax actually owed by me. This submitted expense has not been reimbursed under any other health plan.

_____ _____

Date of Services/Claim Employee Signature (required)

For Dependent Care (Child Care) Reimbursement Claims only:

_____ _____

Taxpayer ID of Provider Address of Provider

NOTE: It is not necessary to submit a separate Claim form with every receipt submitted. Please provide only one Claim form for each monthly reimbursement period and indicate the total dollar value of the receipts attached. All claims must be received at Payroll Management, Inc. by the third Thursday of every month to be processed timely.

MAIL CLAIMS TO:

Payroll Management, Inc
Attention: Claims Processor
100 Manley Road
P. O. Box 1837
Auburn, Maine 04211-1837

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