

Siskiyou County Office of Education
Cafeteria Plan – Medical Care Expense Claim Form

Name:	Last	First	Middle Initial
Social Security No:	Employee No.		

To: Joseph Guerra/Beth Suter, Siskiyou County Office of Education

The undersigned participant in the plan requests reimbursement in the amounts show below. (If additional space is needed, please use a Supplemental Sheet)

Note: Federal law requires that you submit a written statement (such as an itemized bill from the benefit provider), as well as proof that the claim is not being reimbursed by an Insurance Company (Explanation of Benefits or EOB). Also, you will not be entitled to claim this expense as a tax deduction.

MEDICAL CARE EXPENSE(S)				
Date Incurred	Provider Name	Description of Expense	Person for Whom Expense Incurred	Net Amount
Subtotal				
Subtotal from Supplemental Sheet				
Total Medical Expense(s)				

READ CAREFULLY:

The undersigned participant in the plan certifies that all expenses, for which reimbursement or payment is claimed by submission of this form, were incurred during a period while the undersigned was covered under the Siskiyou County Office of Education Cafeteria Plan with respect to such expenses. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid from the plan which relate to such expense.

_____ _____

Employee Signature **Date**

For Plan Administrator Use Only	For Employer Use Only
Payment Authorized By:	Check No.
Amount Authorized:	Date:
Date Authorized	

