

MARYSVILLE PUBLIC SCHOOLS  
CAFETERIA PLAN

REQUEST FOR REIMBURSEMENT

HEALTH CARE REIMBURSEMENT ACCOUNT  
OR  
DEPENDENT CARE REIMBURSEMENT ACCOUNT

EMPLOYEE'S NAME: \_\_\_\_\_

SOCIAL SECURITY NO: \_\_\_\_\_

DATE EXPENSE INCURRED: \_\_\_\_\_

AMOUNT OF EXPENSE: \_\_\_\_\_

NAME OF PROVIDER OF GOOD  
OR SERVICE: \_\_\_\_\_

NAME OF PERSON FOR WHOM  
EXPENSE INCURRED: \_\_\_\_\_

RELATIONSHIP OF PERSON  
TO EMPLOYEE: \_\_\_\_\_

DESCRIBE NATURE OF  
EXPENSE: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

I represent that the information provided above and attached to this Claim is true and accurate, and that I personally incurred and paid the expenses described on behalf of myself, my spouse or a Dependent. No part of this expense is reimbursable from any other source. I agree to provide all information that the Administrator requests in connection with the processing of this Claim.

\_\_\_\_\_  
EMPLOYEE'S SIGNATURE

\_\_\_\_\_  
DATE

PLEASE ATTACH A COPY OF YOUR ORIGINAL RECEIPT

PLEASE USE A SEPARATE FORM FOR EACH CLAIM