

**Plan Name:** \_\_\_\_\_ **Flex Plan Claim for Reimbursement For**

**Employee:** \_\_\_\_\_ **Social Security #** \_\_\_\_\_

**DEPENDENT CARE EXPENSE CLAIMS**

Name of Dependent(s)	Period Covered		Name, Address and Taxpayer ID of Service Provider	Amount Incurred
	From	To		
<b>Total Claims</b>				

NOTE: The total amount claimed under the Plan for any coverage period must not exceed the lesser of your earned income or your spouse's earned income. (If your spouse is either a full-time student or is incapable of taking a full-time job, the limit shall be the lesser of your earned income or \$200 if there is one (1) child or dependent, and \$400 if there are two (2) children or dependents.) The Plan if the service provider is your dependent for federal income tax purposes or is your child or

**UNREIMBURSED MEDICAL EXPENSE CLAIMS**

Date Expense Incurred	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount
<b>Total Claims</b>				

**MAIL TO: Midwest Pension Actuaries, Inc.**  
**30680 Twelve Mile Rd.**  
**Farmington Hills, MI 48334-4848** (248) 539-5000 - Fax (248) 539-5020 - e-mail: kgraf@midwestpension.com  
**ATTN: Cafeteria Claims**

**REMEMBER TO ATTACH ALL APPROPRIATE RECEIPTS**

**Read Carefully**

The undersigned participant in the Plan certifies that all expenses for which reimbursement is requested on this form were incurred during a period while the undersigned was a participant in the Cafeteria Plan with respect to such expenses and that the medical expenses are not reimbursable under any other health plan coverage. The undersigned is fully responsible for the sufficiency, accuracy, and veracity of all information related to this claim, and that unless an expense for which payment or reimbursement is requested is not covered by the Plan, the undersigned may be liable for payment of all related taxes including amounts paid from the Plan which relate to such expense.

\_\_\_\_\_  
*Employee's Signature*

\_\_\_\_\_  
*Date*