

Section 125 Cafeteria Plan Claim Form

Employer Name _____

Last Name	First Name	Middle Initial	Social Security Number	Division Name
Home Address				Daytime Phone
City			State	Zip

Health Care Expense Claims (please attach bills)

Date Expense Incurred	Name of Provider	Expense Description	Person for Whom Expense Incurred	Amount

Dependent Day Care Expense Claims (please attach bills)

Name of Dependents	Service From	Period To	Name/Address/ID# of Provider of Services	Amount

I certify that the expenses being submitted were incurred while covered under the Company's Flexible Spending Account Plan, and have not been reimbursed by any other source. If the claim is not valid, I recognize that I will be liable for payment of all taxes on amounts paid from the Plan which relate to that expense. I also recognize that I cannot claim these expenses on my personal income tax return.

Employee Signature	Date
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Send your completed claim form and a copy of your bills/receipts to:

**The Harrison Group, Inc.
 3 Raymond Drive, Suite 201
 Havertown, PA 19083
 Phone: (610) 853-9075 Fax: (610) 853-9079
 Email: service@theharrisingrouponline.com**