Community Action Partnership of SLO County, Inc.
CAFETERIA PLAN CLAIM FORM

MEDICAL DENTAL VISION

California Pensions
6171 W. Century Blvd Suite 300
Los Angeles, CA 90045 Fax **310-461-0339**

FAX OR MAIL - NOT BOTH, THIS WILL DELAY APPROVAL
APPROVALS GRANTED ON FRIDAYS

.

DATE(S) OF SERVICE	NAME OF PATIENT	DESCRIPTION OF HEALTH CARE	CHARGE

ORIGINAL RECEIPTS WILL NOT BE ACCEPTED

Attached please find **receipts** or other evidence for all expenses claimed on this form (forms will not be returned to the employer or participant). I certify that these expenses will not be reimbursed via any other benefit program, including any insurance provider, employer, or tax exemption, and will not be claimed as an income tax deduction. I am requesting reimbursement only for qualifying expenses incurred after I have become eligible for the Plan and have made an election to participate, and prior to termination of employment, if any, during the Plan Year, regardless of when they were billed or paid for, for eligible Plan participants. Dependent care expenses claimed for the year do not exceed the lesser of my or my spouse's earned income. I authorize my Flexible Spending account(s) to be reduced by the amount(s) requested. I understand that claims for a dependent care or insurance account will only be reimbursed to the extent of available funds, and that any allowable balance will be reimbursed when sufficient or final contributions have been made (although partial interim reimbursements may be made earlier at the discretion of the Plan Administrator). If I have requested recurring reimbursements, I have attached a contract or receipt clearly demonstrating that these services have been or will be provided (1) for one or more amounts totaling my request and (2) by the time I am requesting each payment, and I shall modify or cancel the request should the service cease or the amount be reduced.

X _____ _____

PARTICIPANT'S SIGNATURE **DATE**

_____ ( ) _____

PRINT NAME **TELEPHONE NUMBER**