Health and Dependent Day Care Reimbursement Form

Goshen College Section 125 Cafeteria Plan

Last Name	First Name	Middle Initial	Social Security Number	Division Name

Home Address	Daytime Phone

City	State	Zip

Health Care Expense Claims

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

Dependent Day Care Expense Claims

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

Send the completed claim and receipts to:
The Harrison Group, Inc.
3 Raymond Drive, Suite 201
Havertown, PA 19083
Phone: (610) 853-9075 Fax: (610) 853-9079
Email: service@theharrisongrouponline.com