**Health and Dependent Day Goshen College**

**Care Reimbursement Form 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** |
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**Dependent Day Care Expense Claims**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of Dependents** | **Service From** | **Period To** | **Name/Address/ID# of Provider of Services** | **Amount** |
|  |  |  |  |  |
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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 1908**

**Phone: (610) 853-9075 Fax: (610) 853-9079**

**Email: service@theharrisongrouponline.com**