

**ADDISON NORTHEAST SUPERVISORY UNION
CAFETERIA PLAN**

Health Care Expense Claim Form

Name (last, first, MI)	Social Security #
<p>The undersigned Participant in the Plan requests reimbursement in the amount shown below (please list individually on the reverse side):</p> <p>Please attach the following documentation for each expense (a cancelled check or credit card receipt /statement is not considered acceptable evidence):</p> <ul style="list-style-type: none"> • Services or products covered by any other benefit plan (i.e., health insurance plan): Explanation of Benefits Statement (EOB), or • Services or products NOT covered by any other benefit plan: invoices or receipts which indicate the name and address of the service provider, name of employee or dependent for whom the service was provided, date of service, type of service or product provided and amount of expense. <p>Total Amount of Medical Expenses (from page 2 of this form): \$ _____</p>	
I M P O R T A N T	<p>The undersigned participant in the plan certifies that all expenses for which reimbursement or payment are claimed by submission of this form, were incurred during a period in which the undersigned was covered under the Addison Northeast Supervisory Union Cafeteria Plan with respect to such expenses and that such expenses have not been reimbursed, or are not reimbursable, under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the plan, the undersigned may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid from the plan which relate to such expense. The undersigned further understands that no medical expense tax deduction is permitted for amounts for which reimbursement is made. Furthermore, the undersigned agrees that any amounts paid which are in excess of his or her current account balance will be considered a loan and will be owed to the Plan in the event he or she terminates employment (for any reason) prior to the completion of the current Plan Year.</p>
Participant's Signature	Date
<p>Please return completed form to: Future Planning Associates, Inc. ATTN: Addison Northeast Supervisory Union Cafeteria Plan Administrator P.O. Box 905 Williston, Vermont 05495-0905</p> <p>FAX: 802/878-9455 – If faxing this request, to avoid duplication, DO NOT mail.</p>	
<p>This form must reach Future Planning Associates, Inc. by noon on the 24th of the month • Disbursements are paid the following month •</p>	

ADDISON NORTHEAST SUPERVISORY UNION CAFETERIA PLAN

Dependent Day Care Expense Claim Form

Name (last, first, MI)	Social Security #
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Name of Dependent(s): _____

Period of Care: _____ through _____

Amount Requested (care provider complete Affidavit section below or attach receipts or invoices): _____

Service Provider Information

Name: _____

Address: _____

Provider's Tax ID# or Social Security #: _____

Description _____

Affidavit of Dependent Care Services Rendered

I have provided adult/child care for _____ for the period beginning _____ and ending _____. Services were provided to _____ for a fee of \$_____

Signature of Care Giver _____ Tax ID# or SS# _____ Date _____

N O T E	The total amount claimed under the plan must not exceed the lesser of your wages or salary for the plan year, or the wages or salary of your spouse. (If your spouse is either a full-time student or is incapable of taking care of himself or herself then he or she is deemed to have monthly earnings of \$200 if there is one child or dependent, and \$400 if there are two or more.) No payment may be made under the plan if the service provider is your dependent for federal income tax purposes, or is your child or stepchild and is under age 19.
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I M P O R T A N T	The undersigned participant in the plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form, were incurred during a period in which the undersigned was covered under the Addison Northeast Supervisory Union Cafeteria Plan with respect to such expenses. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the plan, the undersigned may be liable for payment of all related taxes including federal and state income taxes and social security taxes on amounts paid from the plan which relate to such expense. The undersigned further understands that no dependent care tax credit is permitted for amounts for which reimbursement is made.
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Participant's Signature	Date
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Please return completed form to:
 Future Planning Associates, Inc.
 ATTN: Addison Northeast supervisory Union Cafeteria Plan Administrator
 P.O. Box 905
 Williston, Vermont 05495-0905

FAX: 802/878-9455 – If faxing this request, to avoid duplication, DO NOT mail.

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