

SECTION 125 FLEXIBLE BENEFIT PLAN REIMBURSEMENT REQUEST FORM

| | | | |
|-----------------------------|------------|---------------------------|-----|
| Employer | | My Daytime Phone # | |
| Employee's Last Name | First Name | Employee's SS# | |
| Employee's Address (Street) | City | State | Zip |
| Expenses Incurred By: | | Relationship to Employee: | |

CHECK HERE IF NEW MAILING ADDRESS

Reimbursement Payments are issued weekly. Please allow up to three (3) business days for Direct Deposit

ITEMS REQUIRED TO SUBMIT THIS FORM:

- (1) Complete all pertinent information in the spaces provided, sign, date & return to All Valley Administrators by web account, email, fax or mail.
- (2) Attach an itemized statement or receipt to support requested reimbursement(s). Multiple receipts are accepted with a single claim form.
- (3) Statement/Receipt MUST HAVE: Date of Service & Amount of Expense Incurred, Name and Address of Provider as well as Procedures. Daycare must have Tax ID # or SS # clearly listed for approval.

| DATE/S OF EXPENSE | MEDICAL EXPENSE INCURRED | TOTAL MEDICAL REIMBURSEMENT REQUESTED |
|-------------------|--------------------------|---------------------------------------|
| | | |
| | | |
| DATE/S OF EXPENSE | DAYCARE EXPENSE INCURRED | TOTAL DAYCARE REIMBURSEMENT REQUESTED |
| | | |
| | | |

*** Dependent Day Care: **You may complete this section in lieu of a Day Care statement or receipt.** ***

| | |
|------------------------------|----------------------------------|
| Provider's ID #: _____ | Provider's Address: _____ |
| Dependent's Name/s: _____ | Date of Services: _____ |
| _____ | Amount Billed or Received: _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| Dependent Care Provider Name | Day Care Provider Signature |
| | Date Signed |

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 while the undersigned was covered under the Plan with respect to such expenses; and that such expenses have not been reimbursed, or are not reimbursable, under any other benefit plan coverage. The undersigned fully understands that he or she alone is 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 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.

X _____ **X** _____
Signature Date

Please email confirmation of receipt of this claim to: _____@_____.com

ALL VALLEY ADMINISTRATORS, LLC

7525 North Cedar #109, Fresno, CA 93720
Phone (559) 447-1600 Toll Free (888) 344-6914 Fax (559) 447-1889
claims@allvalleyadmin.com

| | | | | | | |
|---|-------------------------|-------------------|-----------|---------|-----------------|---------------|
| To be completed by All Valley Administrators | Date Claim Received: | Approved Benefit: | Excluded: | Reason: | Date Posted: | Posted By: |
|---|-------------------------|-------------------|-----------|---------|-----------------|---------------|