

SECTION 125 FLEXIBLE BENEFIT PLAN

BENNY CARD RECEIPT SUBMISSION FORM

RECEIPTS ONLY ***RECEIPTS ONLY**
PLEASE SEND ALL RECEIPTS FROM BENNY CARD USE, ALONG WITH THIS FORM

This is NOT a Claim Form for reimbursement
 My Daytime Phone # _____

BENNY Employer _____

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

 Check Here if New BENNY Mailing Address

- (1) Complete all pertinent information in the spaces provided, sign, date & return to All Valley Administrators by fax, Email, or mail.
 (2) Attach an itemized statement or receipt to support use of & payments made by your Benny Card. Multiple receipts are accepted with a single form.
 (3) Statement/Receipts **MUST HAVE**: Date of Service, providers name and address , services provided & amount of expense purchased on your Benny Card.
 Daycare must have Tax ID # or SS # clearly listed for approval.

| | | |
|--------------------------------|---|--|
| BENNY Dates of Expense: | <u>Multiple Receipts Attached are Acceptable:</u> BENNY MEDICAL Expense': | <u>Total Med Paid from BENNY CARD:</u> |
| | | \$ |
| BENNY Dates of Expense: | BENNY Day Care Expense: *** | <u>Total Day Care Paid from BENNY CARD:</u> |
| | | \$ |

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

| | | |
|------------------------------|-----------------------------------|---------------------------------|
| Provider's ID #: _____ | Provider's Address: _____ | |
| <u>Dependent's Name/s:</u> | <u>Date of Services:</u> | <u>Amount of Pymt Received:</u> |
| _____ | _____ | _____ |
| _____ | X _____ | _____ |
| Dependent Care Provider Name | Dependent Care Provider Signature | Date Signed |

The undersigned participant in the Plan certifies that all expenses, for which payment has been made by use of the specialized Benny Card 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 payment 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

ALL VALLEY ADMINISTRATORS, LLC

7447 N. First Street #100, Fresno, CA 93720
 (559) 447-1600 / FAX (559) 447-1889
Ljohnson@allvalleyadmin.com

| | | | | | | | |
|--|-------------------------|---------------|------|----------|------------|---------------------|----------------------------|
| To be completed by All Valley Administrators | Date Receipts Received: | Letter/s sent | Date | Approved | Ineligible | Substantiated Date: | RECEIPTS Substantiated By: |
|--|-------------------------|---------------|------|----------|------------|---------------------|----------------------------|