All information must be filled in before claim can be processed

EMPLOYER _____

EMPLOYEE FLEXIBLE BENEFIT PLAN

EMPLOYEE: _____

ADDRESS: _____

CHILD/DEPENDENT CARE EXPENSE ⟶ **$**_____

Please indicate the amount of expense you incurred for the item above since the last Expense Report. Your Reimbursement Check will be sent as soon as possible.

Note: Pension Concepts cannot process and reimburse your claim unless you attach receipts certifying that the above expenses have been incurred.
Also, you need to indicate the amount of each expense and the date such expense was incurred.

** I acknowledge that I have attached supporting documents such as receipts, vouchers, etc. to corroborate the expenses listed above. I also understand that any unused salary reductions (for each expense item) will be forfeited at the end of the plan year. I understand that any expenses for which I am reimbursed under this plan may not be claimed as an income tax deduction. By signing below, I certify that the expenses listed above have not been reimbursed and are not reimbursable under any other health plan coverage; and, I certify that such expenses listed above have not been submitted to this Section 125 Plan previously, or any other Plan in which I or my spouse are covered.

** I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT AND COMPLETE.

_____ _____
Signature Date

Prepared by Pension Concepts & Administration, Inc.
Cafeteria Plan Department
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Lubbock, TX 79423
pensionconcepts.org
806-745-9781
FAX: 806-745-9783