Employer ______________________________

Section 125 Cafeteria Plan Claim Reimbursement Form

Last Name	First Name	Middle Initial	Social Security No
Home Address			Daytime Phone
City		State	Zip

Health Care Expense Claims

Person Incurring Expense	Date Incurred	Provider of Services	Expense Description	Amount

Dependent Day Care Expense Claims

Name of Dependents	Service From	Period To	Name, Address and ID Number of Provider of Services	Amount

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 completed reimbursement form and receipts to:

THE HARRISON GROUP, INC.

3 Raymond Drive, Suite 201 · Havertown, PA 19083 · 610-853-9075 · Fax 610-853-9079

Email service@theharrisongrouponline.com