



**MAC HAIK  
EMPLOYEE CAFETERIA PLAN  
REIMBURSEMENT VOUCHER**

Employer Name	Group No.
Employee Last Name, First	Date of Birth
Street Address, City & State	Zip Code
Phone Number	Identification Number

**UNREIMBURSED HEALTH CARE EXPENSES**

**AMOUNT**

Includes medical, dental, vision or other expenses eligible under the Cafeteria Plan and **not** reimbursed by any other health plan. Attach the itemized receipts for these expenses and/or the “Explanation of Benefits Form” you receive from your group plan.

\$ \_\_\_\_\_

By my signature below, I certify the reimbursements I am requesting are **not** eligible for payment under any other insurance plan.

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

Employer Plan Services will rely upon information provided by the Participating Employee, and shall not be liable for the completeness or truth of any information supplied. Employer Plan Services, Inc. shall have no obligation to any Participating Employee for any act, or failure to act provided Employer Plan Services, Inc. has acted in good faith in exercise of its powers as Claims Administrator of the Plan. The Participating Employee is responsible to maintain appropriate records and receipts for claims made under provisions of the Plan. Participating Employee may be required to supply proof of claims in the form of receipts or canceled checks. The Internal Revenue Service will also require verification in case of individual tax audit.

To file a claim:

1. Complete the form
2. Attach receipts
3. Fax or mail to :

EMPLOYER PLAN SERVICES, INC.  
2180 NORTH LOOP WEST #400  
HOUSTON, TEXAS 77018  
PHONE: (713)932-8917  
TOLL FREE: (800)447-6588  
FAX: (713)369-0703