



**EMPLOYEE CAFETERIA PLAN
REIMBURSEMENT VOUCHER**

Employer Name	
Employee Last Name, First	Date of Birth
Street Address, City & State	Zip Code
Phone Number	Employee Identification Number/SSN

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:

EMPLOYER PLAN SERVICES, INC.
2180 NORTH LOOP WEST #400
HOUSTON, TEXAS 77018
PHONE: (866)369-0705
FAX: (713)369-0703