

Pro-Factors Payroll Service
 318 Park Central East, Suite 306
 Springfield, MO 65806

**Combo Salary Reduction Cafeteria Plan
 Medical Reimbursement Request Form**

Name: _____ SS#: _____

Address: _____

Employer: _____

Instructions: Complete the information below for medical expenses incurred by you, your or other eligible dependents. You must provide hospital or doctor bills or other evidence that the expenses were incurred (canceled checks will not be accepted). Be sure to provide all information requested by this form. If the form is incomplete, it will be returned to you. Print or type the information requested. Then date and sign the form.

	Example	Expense #1	Expense #2	Expense #3	Expense #4	Expense #5
Date(s) Medical Service Actually Provided	10/01/04 to 10/31/04	_____ to _____	_____ to _____	_____ to _____	_____ to _____	_____ to _____
Name of Person Receiving Medical Service and His/Her Relation to Your	Fred Jones <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent
Type of Service	Eyeglasses					
Proof of Expense Attached?	Yes					
Reimbursement Requested	\$250	\$	\$	\$	\$	\$

Total Reimbursement \$ _____

To the best of my knowledge and belief, my statements in this Reimbursement Request Form are complete and true. I certify that I or my family member has received the services described above on the dates indicated, that the expenses qualify as valid medical services under the Plan. If the expense is for my spouse or dependent, I certify that the person listed is my spouse or meets the definition of dependent in the plan. I certify that I have not been reimbursed previously for these expenses under the Medical Reimbursement Component Plan. I certify that these expenses have not been reimbursed, and are not reimbursable under the Major Medical Plan or any other health plan, such as my spouse's plan. If the reimbursement is requested for prescribed drugs, I certify that such drugs are not prescribed for cosmetic purposes (hair growth, weight loss, etc.). I understand that the expenses I am reimbursed may not be used to claim any federal income tax deduction or credit. I authorize a deduction in my Medical Reimbursement Account in the amount of the reimbursement.

 Employee Signature

 Date