PRIMARK
BENEFITS

Cafeteria Plan – Claim for Reimbursement

You must use the following claim affidavit to submit a claim for dependent care expenses, uninsured medical, dental, vision, etc. expenses and for premium conversion.

You must furnish receipts to support your claim, and you must have incurred the expense before you make the claim. The Employer will advise you if any receipt you furnish is not an acceptable receipt.

You must incur the reimbursement expense in the plan year (calendar year) for which you are submitting your claim. You can submit a claim at any time during the plan year or within the 90-day period following the close of the plan year. If you terminate participation in the plan, you must submit your claim no later than 90 days following the date your termination of participation in the plan occurs. You may total and submit several expenses on one claim. However, you must keep claims for premium conversion separate from dependent care expenses.

Please **mail or fax** your claim to **Primark Benefits, 875 Mahler Road, Suite 105, Burlingame, CA 94010**. When you receive your reimbursement check, it also will contain the status of your reimbursement account(s) if you have submitted a claim on the account(s).

CLAIM AFFIDAVIT

Plan Year beginning: _____ and ending _____

Employer: _____

Name: _____ Social Security #: _____

Address: _____

Enter eligible expenses you incurred since your last claim. Please make a copy of your receipts for your records before submitting.

Uninsured Medical/Dental/Vision Expenses $ _____

Health Insurance Premium Expenses $ _____

Dependent Care: $ _____
(Attach Dependent Care Receipt / Page 2)

I have attached a written statement (receipt) to the valid listed expense amounts and state I have not received, nor will I receive, reimbursement from any other employer sponsored benefit plan, nor will I take any of such expenses as an income tax deduction or tax credit on my personal federal income tax return. I understand at the close of the plan year I will forfeit any account balance which did not qualify for reimbursement.

I certify I have examined this affidavit and to the best of my knowledge and belief, it is true, correct and complete.

Signature: _____ Date: _____

Primark Benefits
Phone: 650 692-2043
Fax: 650 692-2260

PRIMARK BENEFITS

Cafeteria Plan – Claim for Reimbursement – Page 2

Dependent Care Receipt

Employer: _____

Name: _____ Social Security #: _____

Service Provider Name/Address: _____

_____

_____

Service Provider EIN or SSN: _____

List Dependents:	**Name**	**Date of Birth**
	_____	_____
	_____	_____
	_____	_____
	_____	_____

Dollar Amount for Services Rendered: $ _____

Date(s) of Service from: _____ to _____

Service Provider Signature: _____ Date: _____

Print Service Provider Last Name: _____

Service Provider Address: _____

_____

You should attach this form to your Claim For Reimbursement form. Although you may submit a claim at any time within the time period stated in the summary plan description, please remember there must be a credit balance in your dependent care account in order for the Employer to reimburse your claim.

Primark Benefits
Phone: 650 692-2043
Fax: 650 692-2260