LEVY COUNTY SCHOOL DISTRICT
CAFETERIA PLAN
HEALTH CARE REIMBURSEMENT CLAIM FORM

_____ **Please check if address change**

Social Security No.:_____

Participant's Name:_____ Daytime Telephone Number_____

Participant's Address:_____

The undersigned participant in the plan requests reimbursement in the amounts shown below: (If additional space is needed, use the reverse side of the form.) ***Please attach receipts, bill or invoices.***

NOTE: Federal law requires that you submit a written statement (such as an itemized statement from your benefit provider) as well as proof that the claim is not being reimbursed by an insurance company. Also, you will not be entitled to claim this expense as a tax deduction.

HEALTH CARE EXPENSE

Date of Service	Name of Service Provider	Describe Expense	Person for Whom Expense Incurred	Net Amount

Total amount of health care expenses (including amounts from reverse side) $_____

READ CAREFULLY

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form, were incurred during a period while the undersigned was covered under the Plan with respect to such expenses. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid from the Plan which relate to such expense. The undersigned further understands that no medical expense tax deduction is permitted for amounts for which reimbursement is made.

_____ _____

Employee's Signature Date

Send Claims to:
Lockard & Williams Insurance Services, P. A.
PO Box 1028
Gonzalez, FL 32560
Fax (850) 479-2923

Phone (800) 530-7222
kanderson1959@earthlink.net

HEALTH CARE EXPENSE

Date of Service	Name of Service Provider	Describe Expense	Person for Whom Expense Incurred	Net Amount

Total $___________

LEVY COUNTY SCHOOL DISTRICT
CAFETERIA PLAN
DEPENDENT CARE CLAIM FORM

_____ **Please check if address change**

Social Security No:_____

Participant's Name:_____ Daytime Telephone Number_____

Participant's Address:_____

Name of Dependent(s):_____

Period Covered:_____

Name and address of person or day care center providing service and description of services:

_____

_____

_____

Provider I.D.#/Signature_____

The undersigned participant in the plan requests reimbursement in the amounts shown below. ***Please attach receipts, bills or invoices.***

Amount $_____

NOTE: The total amount claimed under the plan for any coverage period must not exceed the lesser of your wages or salary for the plan year or the wages or salary of your spouse. (If your spouse is either a full-time student or is incapable of taking care of himself or herself, then he or she is deemed to have monthly earnings of $250 if there is one (1) child or dependent, and $500 if there are two (2) or more.) No payment may be made under the plan if the service provider is your dependent for federal income tax purposes, or is your child or stepchild and is under age 19.

READ CAREFULLY

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form, were incurred during a period while the undersigned was covered under the Plan with respect to such expenses. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid from the Plan which relate to such expense. The undersigned further understands that no dependent care tax credit is permitted for amounts for which reimbursement is made.

_____ _____

Employee's Signature Date

Send claims to:
Lockard & Williams Insurance Services, P.A.
PO Box 1028
Gonzalez, FL 32560
Fax (850) 479-2923

Phone (800) 530-7222
kanderson1959@earthlink.net

Receipt For Dependent Care Services

Dates of Service: _____ through _____

Name of Dependent(s): _____

Name and Address of Service Provider: _____

_____

_____

I.D.#: _____

Amount: $_____ _____

Signature Date