UMC HEALTH SYSTEM
CAFETERIA PLAN CLAIM FORM

EXPENSE REPORT for the Plan Year 1/1/2019 – 12/31/2019

EMPLOYEE: _____

CHANGE OF ADDRESS:_____

CHILD/DEPENDENT CARE $ _____

Please indicate the TOTAL amount of expenses you are claiming for the item above since you last submitted a claim.

NOTE: PENSION CONCEPTS CANNOT PROCESS AND REIMBURSE YOUR CLAIM UNLESS YOU ATTACH RECEIPTS CERTIFYING THAT THE ABOVE EXPENSES HAVE BEEN INCURRED AND INDICATING THE AMOUNT OF EACH EXPENSE, AND THE DATE THE EXPENSE WAS INCURRED.

****I acknowledge that I have attached supporting documents such as receipts, vouchers, etc. to corroborate the expenses listed above. I also understand that any unused salary reductions (for each expense item) will be forfeited at the end of the Plan Year, and that any expenses for which I am reimbursed under this Plan may not be claimed as income tax deductions.**

By signing below I certify that the expenses listed above has not been reimbursed, and are not reimbursable, under any other health plan coverage; and I certify that the expenses listed above have not been submitted to this Section 125 (Cafeteria) Plan previously, or to any other Plan in which I or my spouse are covered.

****I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT AND COMPLETE.**

_____ _____

SIGNATURE **DATE**

JAN HOLMES
PENSION CONCEPTS AND ADMINISTRATION, INC.
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MOST RECENT 2019 FORM FURNISHED TO UMC HEALTH SYSTEM BY PENSION CONCEPTS AND ADMINISTRATION, INC.