

ROMAN CATHOLIC BISHOP OF SLC EMPLOYEES CAFETERIA PLAN
REIMBURSEMENT REQUEST CLAIM FORM

Employee Name _____ S.S. # _____

Diocesan Location _____

Please complete applicable sections of this form and attach appropriate bills, receipts, invoices or other evidences of these expenses before submitting for reimbursement. (Cancelled checks alone are not acceptable.)

List Total of Attached Receipts

Medical Reimbursement Expenses \$ _____

Dependent Care Expenses \$ _____

To the best of my knowledge and belief, my statements in this Request for Reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year. I certify that these expenses have not been previously reimbursed under this or any other benefit plan and will not be claimed as an income tax deduction. I authorize my Flexible Benefits Plan Account to be reduced by the amount requested.

Employee Signature _____ Date _____

PLEASE MAIL COMPLETED FORM TO:

Claudia Murphy
(801) 486-3087 ext 124
fax (801) 483-1255
Alliance Benefit Group
P.O. Box 651366
Salt Lake City, UT 84165-1366