

**SECTION 125 BENEFIT PLAN
REIMBURSEMENT SUMMARY SHEET**

(Filed with the Business Office the Friday prior to a payroll)

I certify that I have incurred these amounts during the indicated Plan Period. Furthermore, I have not been reimbursed, nor do I expect to be reimbursed, for any of these expenses by any insurance company or policy. I declare that I will not deduct these expenses on my federal tax return.

Attached are written statements from an independent third party stating the date the expenses have been incurred and the amounts of the expenses.

In addition to the expenses indicated, group insurance premiums as shown on the Prospective Determination Statement filed at the beginning of the plan year are also included and have been deducted from my paychecks.

I submit this Summary Sheet in accordance with all terms and conditions of the document describing the Section 125 Plan. To the best of my knowledge I am claiming reimbursements only for eligible expenses incurred during the plan year (September 1 to August 31).

Plan Year _____
(00-01, 01-02)

Medical Expenses	AMOUNT
Payments toward Deductible or Co-payment	_____
Payments to Physicians	_____
X-ray and Laboratory Fees	_____
Chiropractic and Osteopathic Services	_____
Other Medical Payments	_____
Vision Care	_____
Hearing Aids	_____
Dental Expenses	_____
Prescription Drugs	_____
Subtotal for Medical Expenses	_____
Dependent Care Expenses	_____
Grand Total for this Pay Period	_____

NAME (please print) _____

SOCIAL SECURITY # _____

SIGNATURE _____

DATE _____