CPM, Inc.

Employer: _____

Section 125 "Cafeteria" Plan

Reimbursement Request Form

Employee Name: _____ Social Security Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

MEDICAL EXPENSE **DEPENDENT CARE**

	Request #1	Request #2	Request #3	Request #4	Request #5	Request #6	Request #7	Request #8		Request #1	Request #1
Date Medical Service Provided	_____ to _____	_____ to _____	_____ to _____	_____ to _____	_____ to _____	_____ to _____	_____ to _____	_____ to _____	Date(s) Dependent Care Service Provided	_____ to _____	_____ to _____
Name of Person Receiving Medical Service and Relationship to You	☐ Self ☐ Spouse ☐ Dependent	☐ Self ☐ Spouse ☐ Dependent	☐ Self ☐ Spouse ☐ Dependent	☐ Self ☐ Spouse ☐ Dependent	☐ Self ☐ Spouse ☐ Dependent	☐ Self ☐ Spouse ☐ Dependent	☐ Self ☐ Spouse ☐ Dependent	☐ Self ☐ Spouse ☐ Dependent	Name and Age of Dependent		
Type of Service									Name, Tax ID # and address of Provider		
Proof of Expense Attached?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	Proof of Expense Attached?	☐ Yes ☐ No	☐ Yes ☐ No
Total Expense									Total Expense		
Amount Paid by Other Plans											
Reimbursement Requested									Reimbursement Requested		

TOTAL MEDICAL REQUESTED $_____ **DEPENDENT CARE REQUESTED $_____**

To the best of my knowledge and belief, my statements in this Reimbursement Request are complete and true. I have read, understand and make the certifications contained in the Certificate of Qualifying Dependent Care Expenses on the reverse side of this request form. I understand that these dependent care expenses may not be used to claim any Federal Income Tax deduction or credit (including the dependent care tax credit). I authorize a reduction in my Dependent Care Assistance Account in the amount of the reimbursement.

A Health FSA (Cafeteria Plan) may reimburse a medical expense only if the participant provides a written statement from an independent third party (health insurance benefit provider) indicating the amount of such expense and the amount of that expense that has (or has not) been reimbursed. This must be filed with your reimbursement request.

_____ _____

Employee Signature Date

Mail, e-mail or Fax to:
CPM, Inc.
1220 SW Executive Drive
Topeka, KS 66615
Phone (800) 999-1781
claims@corpplan.net
Fax (785) 273-6850

CERTIFICATE OF QUALIFYING DEPENDENT CARE EXPENSES

By signing and submitting this Dependent Care Reimbursement Request, you are certifying that expenses for which you request reimbursement meet all of the following conditions:

1. The expenses are incurred for services rendered after the date of your election to receive dependent care assistance benefits and during the plan year to which the election applies.
2. The expenses are incurred so you (and your spouse, if you are married) can work or look for work. Exception: If your spouse is not working or looking for work when the expenses are incurred, you certify that he or she is a full-time student or is physically or mentally incapable of caring for himself or herself.
3. The amount of the reimbursement requested, (when aggregated with all other reimbursements received by you under the Plan during the same calendar year), do not exceed the lesser of
   (A) your earned income; or
   (B) if you are married, your spouse's actual or deemed earned income (see below).
   (Your spouse is deemed to have monthly earned income of $200 ($400 if you are incurring dependent care expenses for more than one dependent), if your spouse either is a full-time student or is physically or mentally incapable of caring for himself or herself.)
4. Each dependent for whom you incur the expenses is
   (A) a person under the age of 13 for whom you are entitled to claim a dependency exemption on your Federal income tax return, or
   (B) your spouse or a person who is your dependent under Federal tax law (even if you may not claim the dependency exemption on your Federal income tax return), but only if he or she is physically or mentally incapable of caring for himself or herself.
5. You (or your spouse together) are providing at least 50% of the cost of maintaining your household, and the expenses are incurred when at least one member of your household is a person described in 4(A) or 4(B) above.
6. The expenses are incurred for the care of a dependent, or for related incidental household services.
7. If the expenses are incurred for services outside your household, they are incurred for the care of a dependent who is described in 4(A) above (or who is described in 4(B) above and regularly spends at least 8 hours per day in your household).
8. If the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than 6 individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.
9. The person who provided care was not your spouse or a person whom you can claim as a tax dependent. If your child provided the care, he or she must be age 19 or older at the end of the year in which the expenses are incurred.
10. The expenses are not paid for services outside your household at a camp where the dependent stays overnight.

QUALIFYING MEDICAL EXPENSES

EXPENSES FOR WHICH YOU CAN RECEIVE REIMBURSEMENT INCLUDE:

Medical and dental plan deductibles and co-payments

Eye exams, eyeglasses, contact lenses, and other vision expenses

Payments to a treatment center for alcoholism.

Chiropractics.

Psychotherapy.

Hearing exams, hearing aids, other hearing expenses

Prescription drug co-payments

Cost of maintaining guide dogs.

Special equipment installed in cars for the disabled.

Acupuncture.

Medical care in a qualifying nursing home.

The cost of equipment that displays the audio part of television programs as subtitles for the deaf.

Cosmetic surgery or other similar procedures (but only if the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease). "Cosmetic Surgery" means any procedure which is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.

EXPENSES FOR WHICH YOU MAY NOT BE REIMBURSED INCLUDE:

Health insurance premiums

Cosmetic surgery or other similar procedures (except as permitted above)

The salary expense of a nurse to care for a healthy newborn at home

Bottled water

Diaper service or diapers

Vitamins taken for general health purposes

Automobile insurance premiums

Funeral and burial expenses

Custodial care

Health club dues

Maternity clothes

Cosmetics, toiletries, toothpaste, etc.

Uniforms

Transportation expenses to and from work, even though a physical condition may require special means of transportation.

Household and domestic help (even though recommended by a qualified physician due to an employee's or dependent's inability to perform physical housework).

Costs for sending problem children to a special school for benefits the child may receive from the course of study and disciplinary methods.

Note: This list is not meant to be all-inclusive, as other expenses not specifically mentioned may also qualify. For additional information, check your Summary Plan Document or contact your Plan Administrator.