

Plan Year _____

ALBIN ENGINEERING SERVICES, INC.

CAFETERIA PLAN CLAIMS VOUCHER

NAME: _____ SS#: _____ / _____ / _____

Record below the amount of eligible expenses incurred since your last claim for which you would like to be reimbursed.

Health Expenses: Unreimbursed Medical, Dental, Vision \$ _____

Dependent Day Care Costs \$ _____

TOTAL \$ _____

In requesting reimbursement, I hereby acknowledge that the receipts to support my claim are attached, and are valid cafeteria claims. Any unused Salary Reductions as shown on the reimbursement checkstub will be forfeited after 90 days following the later of the end of the plan year or the extended claims period that is two months and 15 days after the end of the year.

I certify that the above information and claim is correct and complete:

Employee/Participant Signature

Date of Claim

CAFETERIA PLAN CLAIMS VOUCHER

This claims affidavit is to be used to make claims from your account for eligible benefits you have incurred since your last reimbursement.

To be eligible for reimbursement, all expenses must have been incurred AFTER you began Salary Reductions. You must submit receipts or documentation showing that you have paid for (or contracted to pay for) and received the services prior to requesting reimbursement. Statements and receipts should indicate date of service, and the type of service rendered. For Dependent Care costs, please indicate on the receipt name of payee, amount and name of dependent. We will not issue reimbursement checks without receipts or billing statements.

If you do not submit a claim in any month, the credits accumulate and claims can be made against them at a later date in the year. If the claims are for an amount greater than your current balance, but not exceeding the annual election amount, payment will be made in full, less any previously reimbursed claims (this excludes Day Care Expenses). Several expenses can be paid with one voucher. Claims for Medical and Dependent Day Care must be shown separately on the voucher; the balance in your Medical account cannot be used to pay for expenses for Dependent Day Care and vice versa.

Please turn in your voucher to your employer or mail to the address below by the designated date each month. The check will be given to you along with your payroll check. A report to explain your account balance will also be included on the check stub. If a voucher is received after the due date, it will be kept on file until the next month's checks are processed.

HICKS FLEXIBLE BENEFIT SYSTEMS
3459 West Shaw
Fresno, CA 93711
Attention: Stacey Statham

