CITY OF TURLOCK

CBA Administrators

A Full Service Administration Company

Flexible Spending Account Reimbursement

Name:______________________________ Soc. Sec #: ______________________________

Address:____

City: ______________________________ State: ________________ Zip Code:__________

Dependent Care Expense Claims

Name of Dependent (s)	Period Covered To	From	Name, Address and Taxpayer Identification Number of Provider of Service	Amount Incurred
			Total Dependent Care Expense Claim	

Unreimbursed Medical Expense Claims

Name of Service Provider	Date Expense Incurred	Description of Expense	Person For Whom the Expense Was Incurred	Net Amount
			Total Medical Expense Claim	

Read Carefully

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the company's Cafeteria Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to the claim which is provided by the undersigned and that unless an expenses for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxed including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

Employees Signature: ____ Date: ________________

For prompt attention PLEASE FAX to CBA Administrators at (559) 271-0419

Mail to: CBA Administrators ◆ 4704 W. Jennifer ◆ Suite 104 ◆ Fresno ◆ CA ◆ 93722