CPA, INC.
420 Washington Street, Suite 100
Braintree, MA 02184
(781) 848-8477 (Fax)

CLAIM VOUCHER

☐ Address change

Go to www.cpa125.com for additional forms/information

EMPLOYER: _____

EMPLOYEE: _____ **SS#:** _____-_____-_____

ADDRESS: _____ **CITY:** _____

STATE: _____ **ZIP:** _____ **PHONE: ( )** _____

E-MAIL ADDRESS: _____

UNREIMBURSED MEDICAL EXPENSES (Participants & Eligible Dependents -*as defined by the IRS guidelines*)

ITEMS (group similar items)	DATE OF SERVICE	AMOUNT
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____
	TOTAL:	**$**_____

DEPENDENT/CHILD CARE EXPENSES (daycare)

_____	_____	$_____

OTHER ACCOUNT EXPENSES (e.g. COBRA)

_____	_____	$_____

TRANSPORTATION ACCOUNT EXPENSES (For Participants Enrolled in Qualified Parking/Transit Plans ONLY)

PARKING (2010-IRS Monthly max $230)	_____	$_____
TRANSIT (2010-IRS Monthly max $230)	_____	$_____

All medical claims submitted require copies of bills/statements/receipts showing date and type of service. (No cancelled checks/credit card receipts). All claims must be received 2 days prior to claim payment day. Direct deposit payments are processed weekly (Wednesday). Checks are processed at least twice a month (every other Wednesday). Please allow 3 business days to receive your check. Minimum payment is $20.00.

This is to certify that I have incurred the expenses listed above that qualify for reimbursement under my employer's Cafeteria Plan. I have not been reimbursed from any other source including insurance programs or other programs offered by my employer. None of these expenses have previously been submitted. I understand and agree that since these expenses are to be reimbursed they may not be claimed as deductions for income tax purposes. Additionally, I am aware that unused funds may be forfeited or otherwise handled in accordance with the plan document and the current IRS law. I hereby request reimbursement for these claims.

PARTICIPANT'S SIGNATURE: _____ **DATE:** _____