CBS Administrators
P.O. Box 36-Jamestown, Ca 95327
408.915.2280, Fax: 408.323.4999
Email csamuels@cbsadmin.com for **SCANNED CLAIMS ONLY**

Claim for Reimbursement

Company name_____

Name _____ Social Security # _____Employee Id _____

Address _____ City/State/Zip _____

Work Phone Number _____ Home Phone Number _____ DOB _____

Email Address:_____

❑ Check if the above address is new ❑ **I AM ENROLLED IN A HSA PROGRAM**

Unreimbursed Medical Expense Claim

Date Expense Incurred	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount

Receipts Required

Total Medical Care Expense Claim	

Dependent Day Care Expense Claims

Name of Dependent(s)	Period Covered		Name, Address and Taxpayer Identification Number of Provider of Service	Amount Incurred

Receipts Required

*TOTAL DAY CARE EXPENSE CLAIM	

*NOTE: The total amount claimed under the Plan for a coverage period must not exceed the lesser of your earned income for the plan year or the earned income of your spouse (If your spouse is either a full time student or is incapable of taking care of himself or herself, then he or she is deemed to have monthly earnings of $200 if there is one (1) child or dependent, and $400 if there are two (2) or more). No payment may be made under the Plan if the service provider is your dependent for federal income tax purposes, or is your child or stepchild and is under age 19.

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 this claim which is provided by the undersigned and unless an expense for which payment of reimbursement is claimed is a proper expense under the plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the plans which relate to such expenses.

_____ _____

Employees Signature Date