

CITY OF TURLOCK

Flexible Spending Account Reimbursement

◆
CBA Administrators
A Full Service Administration Company

Name: _____	Soc. Sec #: _____
Address: _____	
City: _____	State: _____ Zip Code: _____

Dependent Care Expense Claims

Name of Dependent (s)	Period Covered		Name, Address and Taxpayer Identification Number of Provider of Service	Amount Incurred
	From	To		
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 expense for which payment or 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 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