



Professional Benefit Services, Inc.
Effordable administration of employee benefit plans

CLAIM FORM CAFETERIA PLAN

Employer:			
Participant Name:		Employee ID: (last 4 SSN)	
Mailing Address:		<input type="checkbox"/> Check box if this is a change	Phone Number:
City:	State:	Zip:	Email Address:

SECTION 125 REIMBURSEMENT EXPENSES

Health Care/Flexible Spending Expense (FSA)

\$

Dependent Daycare Expense (DCA)

\$

Other Insurance Premium (Individually owned Supplemental Policy)

\$

This is to certify that I have incurred expenses in the amounts shown above that qualify for reimbursement under the provisions of my employer's Section 125 Cafeteria Plan.

I am attaching copies of documentation from my service provider that shows date(s) and type(s) of service (i.e., a bill or receipt from the Doctor, hospital, lab, pharmacy, day care provider, etc.). I certify that these expenses have been incurred by myself or my tax dependent and have not been reimbursed, or are not reimbursable, under any other health plan coverage. Since these expenses are being reimbursed by my employer, they may not be claimed on my income tax filings at year end. I understand that it is my responsibility to inform PBS of any address change.

To view your balance and transaction history, please visit <https://www.mywealthcareonline.com/pbsfsa>

Participant Signature: _____ Date submitted: _____

***Download the new claim submission app and submit your claims from your smartphone.
 Available for android and iphone.



Send claims to: Professional Benefit Services, Inc.
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