CDS Family & Behavioral Health Services, Inc.

CLAIM FOR REIMBURSEMENT

Name _____ Social Security # _____

Unreimbursed Medical Expense Claims				
Date of Expense	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount
TOTAL MEDICAL SPENDING EXPENSE CLAIM				$ $0.00

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. 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 that unless an expense for which payment or reimbursement is claimed in a proper expense under the plan, the undersigned may be liable for payment for all related taxes including federal, state or city income tax on amounts paid from the plan which relate to such expense.

_____ _____

Employee's Signature Date