Plan Name:_____ ***Flex Plan Claim for Reimbursement Fori***

Employee:_____ Social Security #_____

DEPENDENT CARE EXPENSE CLAIMS

Name of Dependent(s)	Period Covered From	To	Name, Address and Taxpayer I of Service Provider	Amount Incurred
			Total Claims	

NOTE: The total amount claimed under the Plan for any coverage period must not exceed the lesser of you earned income of your spouse. (If your spouse is either a full-time student or is incapable of taking have monthly earnings of $200 if there is one (1) child or dependent, and $400 if there are two (the Plan if the service provider is your dependent for federal income tax purposes or is your child or

UNREIMBURSED MEDICAL EXPENSE CLAIMS

Date Expense ncurre	Name of Service Pr	Expense Description	Person for Whom Expense Incurred	Net Amount
			Total Claims	

MAIL TO: **Midwest Pension Actuaries, Inc.**
30680 Twelve Mile Rd.
Farmington Hills, MI 48334
ATTN: Cafeteria Claims

Telephone (248) 539-5000 - Fax (248) 539-5020 - e-mail: kgraf@midw

REMEMBER TO ATTACH ALL APPROPRIATE RECEIPTS

Read Carefully

The undersigned participant in the Plan certifies that all expenses for which reim submission of this form were incurred during a period while the undersigne Cafeteria Plan with respect to such expenses and that the medical expenses not reimbursable under any other health plan coverage. The undersigned fully responsible for the sufficiency, accuracy, and veractiy of all information relati undersigned, and that unless an expense for which payment or reimbursement is c the Plan, the undersigned may be liable for payment of all related taxes including amounts paid from the Plan which relate to such expense.

_____ _____

Employee's Signature *Date*