



**THE KEMPTON GROUP
ADMINISTRATORS, INC.**

**Request for Reimbursement
from
Section 125 Account**

Please complete applicable spaces on this form, attach the necessary information, and forward to:
Kempton Group Administrators
P.O. Box 54889
Oklahoma City, Oklahoma 73154-1889
Fax: 405-556-6231

DATE: _____ EMPLOYER: _____ GROUP NUMBER: _____

EMPLOYEE SOCIAL SECURITY NUMBER: _____

EMPLOYEE NAME: _____
Last First Middle

Please check here and complete the following if you have recently changed your mailing address.

HOME ADDRESS: _____
Number/Street City State Zip

- **HEALTH EXPENSES** (Please Note: Section 125 regulations require that you attach a copy of explanation of benefits and/or itemized statement of services as well as proof that the claim is not being reimbursed by an Insurance Company.)

Provider of Services: _____

Date of Services: _____

Amount Paid: _____

- **CHILD CARE EXPENSES**

Provider of Services: _____

Tax ID# or S.S.# of Provider: _____

Name of Child or Children _____

Dates of care to be reimbursed: From: _____ To: _____

Amount to be reimbursed: _____

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 (i.e., services were provided) during a period while the undersigned was covered under The Cafeteria Plan with respect to such expenses and that such 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 that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid from the Plan which relate to such expense. The undersigned further understands that no medical expense tax deduction or credit and if applicable that no dependent care tax credit is permitted for amounts for which reimbursement is made.

Employee's signature

Date _____