Secure Benefits Systems Claim for Reimbursement

Fax 1-800-421-6737
Mail: P.O. Box 469; Okoboji, IA 51355
Email: Customercare2@sbsc.info

Employer_____ Daytime Phone #_____

Name_____ Social Security #_____

Daycare Expense Claims

Daycare requires a receipt from the child care provider showing dates of service

Name of Dependent(s)	Period From	Covered To	Name & Address of Service Provider	Amount Incurred

TOTAL DAYCARE EXPENSE CLAIM	

Employee Owned Private Premium Insurance Expenditure

Employee owned private Premium requires proof of payment or a current bill/statement showing coverage period and amount (Health insurance is NOT eligible)

Date of Coverage	Name and # of Insurance Policy	Employee Policy Holder Name	Net amount

IRS requires a copy of an Explanation of Benefits from the insurance company or bill from the provider showing name of provider, date of service, service provided, whom the service is for and what you owe after insurance has paid.

Date of Service	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount

TOTAL MEDICAL CARE 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. 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 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 also states that he or she will not receive reimbursement for the above charges from any other source.

_____ _____

 Employee's Signature (REQUIRED) Date