

EMPLOYEE INFORMATION *(Please Print)*

Check here if address has changed

Name: _____ SSN: _____
 Address: _____ Email: _____
 City, State, Zip: _____ Day Phone: _____

ORTHODONTIC EXPENSES

This claim form is for participants who would like to set up an ongoing monthly reimbursement for their orthodontic expenses. This eliminates the need to submit monthly claim forms as services are provided. By having your provider complete this form, a payment schedule can be established to automatically issue a reimbursement directly to you each month. However, beginning January 1, 2007, the IRS has allowed payment in full for your orthodontic expenses. If this is an option you would like to discuss, please contact our Customer Service Department at 1-800-865-6543.

Patient's Name:	<input type="text"/>	
Treatment Start Date:	<input type="text"/>	
Total Treatment Fee:	<input type="text"/>	A
Insurance Payment/Reimbursement:	<input type="text"/>	B
Total Out-of-Pocket Expense:	<input type="text"/>	C =(A minus B)
Down Payment:	<input type="text"/>	D
Remaining Balance:	<input type="text"/>	E =(C minus D)
Number of Months of Treatment:	<input type="text"/>	F
Monthly Reimbursement Amount Allowed:	<input type="text"/>	G = (E/F)
Orthodontic Contact Information:	Name: _____ Address: _____ Phone: _____	

I certify that our office will provide orthodontic care as described above. Our office further certifies that this orthodontic service is for treatment and is NOT strictly for cosmetic purposes.

Signature of Orthodontic Care Provider

Date

READ CAREFULLY

The above is a true and accurate statement of all expenses incurred by my eligible dependents or me on the date(s) indicated, and were incurred while I was covered under the Flexible Spending Account. I understand that I cannot claim any reimbursed expenses on my income tax return, and that I may be liable for payment of all related taxes including Federal, State, or City income tax and any associated penalties on the amounts paid for any expense improperly claimed under the provisions of the Flexible Spending Account.

Participant Signature

Date

Mail To: myCafeteriaPlan, 432 East Pearl St., Miamisburg, OH 45342
Fax To: 937.865.6502 **Email To:** claims@myCafeteriaPlan.com
 To contact Customer Service, call 800.865.6543

Access your account information 24 hours a day, seven days a week on our web site: www.myCafeteriaPlan.com