Request for Reimbursement under Grace Period (Refer to Section C)

(818) 842-0147
(800) 350-0148

Instructions For Submitting A Claim:
1. Complete all information in Section A
2. Complete Section B - (attach all invoices, receipts, and cancelled checks.)
   Please make copies for your records.
3. Read then sign where indicated in Section C.

Section A - Employee Identification

Employer ______________________________

Employee ______________ SS No. ______________ D.O.B. ______________

Address ______________________________

Sex ☐ M ☐ F Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Section B - Claims and Expenses

* Health Care Expenses are expenses incurred by you or your dependents whihch have not been or will not be reimbursed by any medical, dental or vision insurance. Health Care includes the prevention, diagnosis, treatment and care of a physical or mental defect, illness, injury or disease.

* Dependent Care Expenses are expenses incurred to enable you to work. If you are married and your spouse is not a full time student or is not incapable of self-care, the expenses mut be to enable you and your spouse to work. These expenses must be for your dependent who is under age 13 (for whom a personal exemption deduction is allowed for federal income tax purposes), the care of your dependent spouse who is physically or mentally incapable of self-care, of household services in connection with the care of such a person(s).

Expenses Incurred For (name)	Relationship	Type * H * D	Dates Services Rendered	Total Expense	Amount Paid By Another Plan	Amount Paid By You
TOTAL						

Section C - Employee Certification

I hereby certify that all items requested to be reimbursed have not and will not be covered by any other plan of any employer or other person. I further certify that such items will not be deducted or taken as tax credits on my personal federal and state income tax return for any year.

IMPORTANT: ONCE YOU CLAIM CURRENT PLAN YEAR EXPENSES (INCURRED DURING THE PRIOR PLAN YEAR GRACE PERIOD) TO BE REIMBURSED FROM PRIOR PLAN YEAR BENEFITS, YOU MAY NOT FILE A CLAIM FOR EXPENSES INCURRED IN THE PRIOR PLAN YEAR.

EMPLOYEE SIGNATURE (If not signed, this form is invalid and will be returned)	DATE

ABA RFR Grace - 001 REV 7/05

WWW.BENEFITSABA.COM

Section 125 & 129 ProPlus Plan claim Form

Submit form to:

Affordable Benefit Administrators, Inc.
P.O.Box 10787
Burbank, CA. 91510-0787