CHIPTON-ROSS
The Power of People

SECTION 125 CAFETERIA PLAN – CLAIM FORM

Fax or email to 877-828-7319 / payroll@chiptonross.com

Participant Information

Please check if this is a new address ☐ Last 4 digits of participant's SS #:_____

Name: _____
(Last) (First) (M.I.)

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Daytime Phone: _____

Medical, Dental, or Vision Insurance Premiums

Provider Name	Coverage Period		Requested Amount of Reimbursement
	Total:		

When filing the claim forms for reimbursement under your (health, dental, and vision) insurance, be sure to attach copies of statements from your insurance company, showing the date of premium and amount paid, a cancelled check, or credit card statement. Please note that this is for Monthly Medical, Dental and/or Vision Premiums only, this is **NOT** a Flexible Spending Account.

Dependent/Child Care Claims

When claiming dependent care expense, please provide a written receipt of statement, including date and amount of expense incurred. (Handwritten receipts are acceptable for childcare.) Documentation will not be returned.

Effective January 1, 1989, the I.R.S. requires the dependent child care provider(s) to furnish the provider's current name, address, Tax Identification Number (or Social Security Number) to the tax payer making claim, unless the provider is exempt from federal income taxation as described in I.R.C. Section 501(c)(3). A provider failing to comply with this law is subject to $50 fine for each such failure unless proven that failure is due to reasonable cause, not willful neglect.

Name of Dependent Receiving Care	Age	Relationship	Provider Name & Address	TIN/SSN	Dates of Care	Requested Amount of Reimbursement

Salary Reduction Agreement

I have read and understand the explanation I have received regarding my options under the CHIPTON-ROSS, INC. Section 125 Plan Plan. I understand I have the right to have the company make a deduction from my salary on a pretax basis during the plan year. I acknowledge that my election is irrevocable unless there is a change in my status. A change in status includes: marriage; divorce; death of a spouse or dependent; birth or adoption of a child; change in number of dependents; termination of employment or commencement of employment; commencement or return from an unpaid leave of absence; or any change in employment status that affects eligibility (a change in residence of you, your spouse or children; or your dependents either satisfies or ceases to satisfy requirements for coverage in age, student status, or any similar circumstances; or a change in your or your spouse's employment status).

The dependent care information including provider(s) name, address, TIN/SSN is correct to the best of my knowledge. I understand I may incur penalties of perjury if the information is knowingly misstated.

I hereby apply for the options listed above. If necessary, I authorize CHIPTON-ROSS, INC. to adjust my pay as required by my elections. I understand that the benefit options I have elected will remain in force from January 1, 2019 until December 31, 2019 unless my family status or employment status changes.

Employee Signature: _____ Date: _____