Wisconsin Automobile & Truck Dealers Association
CAFETERIA PLAN
PO Box 5345 Ph: 608/251-5577
Madison, WI 53705 Fax: 608/251-5151

CAFETERIA PLAN REIMBURSEMENT FORM

PART 1 EMPLOYEE INFORMATION

Social Security #_____ Employer:_____

Employee Name:_____ Plan Year: _____

Employee Address (if changed):_____

EMPLOYEE INSTRUCTIONS

Please Read These Instructions Before Completing the Withdrawal Request

1. Complete a reimbursement form for every submission. If you have more than one receipt or statement, you can fill out one reimbursement form for all of them. You must submit a signed reimbursement form for your claim to be processed.
2. Attach a copy of third-party claim substatiation to the reimbursement form. This may be an explanation of benefits, from your insurance carrier, a bill, a statement, or receipt for services rendered. All must show original date of service **(the date of service, not the date of payment, must fall within the plan year for which you are enrolled),** patient name, charge, and provider name. Dependent care claims must have a receipt showing date(s) of service, name of dependent for whom care was provided and amount paid. Federal tax ID number must be written on the reimbursement form.
3. Mail or fax to: WATDA Services Inc. Cafeteria Plan, P.O. Box 5345, Madison, WI 53705-0345 or via fax at 608/251-5151.

PART 2 HEALTH CARE EXPENSES

Patient's Name	Relationship	Dates of Service	*Type of Expense	Withdrawal Request Amount

(*Expense type means: Dental, Vision, Prescription Drugs, etc.)

TOTAL Health Care Expenses
Must equal or exceed $10 $

PART 3 DEPENDENT CARE EXPENSES (Day Care Only)

Dependent's Name	Dates of Service	Providers Social Security # or Tax ID #	Withdrawal Request Amount

TOTAL Dependent Care Expenses $

To the best of my knowledge and belief, my statements in this Reimbursement Form are complete and true. I certify these expenses are for valid medical services or dependent care provided on the dates indicated, and have not been and are not reasonably expected to be reimbursed under this or any other health or dependent care assistance plan and that the expenses qualify for reimbursement under the respective Plan. I understand that these expenses may not be used to claim any Federal income tax deduction or credit.

Employee Signature:_____ **Date:**_____