MDPC
Memorial Drive
Presbyterian Church

Section 125 Cafeteria Plan
Request for Reimbursement Form

FSA Administrator
10515 Saddlehorn Trail | Houston, TX 77064
Phone: 281-890-3042 | Fax: 281-970-2440

Plan Year _____

Participant _____ S.S.N. _____

Address _____

Date _____

Type of Expense	**Amount Requested**
Medical Care Reimbursement	$
Dental Care Reimbursement	$
Dental Care Reimbursement	$

To the best of my knowledge and belief, statements in the Request for Reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants. I certify that these expenses have not been previously reimbursed under this or any other benefit plan and will not be claimed as an income for income tax deduction. I authorize my Flexible Compensation Account to be reduced by the amount requested.

_____ _____/_____/_____
Employee's Signature Date

For Administrative Use Only

Date of Reimbursement _____/_____/_____

Check Number _____