EMPLOYER'S RESOURCE GROUP, INC.
SECTION 125 "CAFETERIA PLAN"
Reimbursement Voucher fax to 936-6353

EMPLOYEE INFORMATION

Company Name:		
Name of Employee (Last, First, M.I.)		Social Security #
Address	City & State	Zip Code
Daytime Phone	Email Address	

CHECK HERE IF THIS IS A NEW ADDRESS

Please complete the worksheet below by indicating the date your expense was incurred, the type of expense being reimbursed, the name of person for whom expense was incurred, and the amount of the expense. Only include expenses for you or your dependents and expenses for which you have **not** previously filed for reimbursement.

Date of Expense	Name of Person for Whom Expense Was Incurred & Relationship	Type of Expense *(Med, Dental, Rx, Vision)*	Amount of Expense
			$
			$
			$
			$
			$
			$
			$
TOTAL			$

MEDICAL EXPENSES: For each medical expense listed above, attach an original statement, receipt, bill or explanation of benefits. For expenses that are or may be covered under your health insurance plan, submit your bills to the insurance company(ies) and then submit the insurance explanation of benefits showing the amount of expenses not covered by insurance with this form. You should keep a copy of each statement, bill, or statement of benefits submitted with this form for your records.

I HEREBY CERTIFY that the expense(s) shown above has not been, and will not be paid or reimbursed by an insurance company, or from any other source. I understand that any amount not used for qualified expenses by the end of the plan year will be forfeited to my employer.

Date Signed ____________________ Signature of Employee ____________________

NOTE: MEDICAL EXPENSES WHICH HAVE BEEN REIMBURSED UNDER THIS PLAN ARE NOT DEDUCTIBLE BY THE EMPLOYEE FOR FEDERAL INCOME TAX PURPOSES.

Fax, Mail or Email this Form to:

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(405) 755-7689 / Fax: (405) 936-6353
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