DUNDY COUNTY STRATTON SCHOOLS

Request for Cafeteria Plan Reimbursement

This is a fillable form. Please complete the TOP portion for child care reimbursement; the BOTTOM portion for medical care reimbursement. Upon completion, print the form and attach an Explanation of Benefits from the insurance company or a receipt that shows the date of service for medical reimbursement.

Name _____

Address _____

City, State, Zip _____

DEPENDENT CARE

Name of Child	Beginning Date	Ending Date	Amount Requested

Dependent Care Provider _____ Phone _____

Provider Signature _____ Date _____

MEDICAL CARE

Patient Name	Date of Service	Description	Provider	Amount Requested
			TOTAL	0

Employee Signature

Date Submitted