

**SECTION 125
Request For Reimbursement Claim Form**

Employer Name _____

Employee Name _____ Soc. Sec. # _____ - _____ - _____

Address _____

City, State, Zip _____

This request is for reimbursement of: Healthcare Expenses Dependent Care Expenses

List of Expenses

- **Healthcare Reimbursement:** (medical, dental, vision and other healthcare expenses not paid by your insurance plan): Attach copy of original bill showing service, procedure code, date of service; Explanation of Benefits form (EOB); paid receipts, or paid bill with above information.
- **Dependent Care:** Attach receipts showing dates of service, dependent name, Social Security number of provider; paid bill with above information.

Date Service Incurred	Payment Made To	Services Provided	Amount
			\$
			\$
			\$
Total			\$

Spouse and Dependent(s) Section

Services Provided For (list name(s))	Birthdate	Relationship

To the best of my knowledge and belief, my statements in this Request For Reimbursement Claim Form are complete and true. I certify that I or my family member has received the services described above on the dates indicated and that the expenses qualify as valid medical services under the Plan. Expense receipts, paid bills and evidence of expenses are attached. OEA Choice Trust reserves the right to request additional documentation to support this claim.

Signature _____
Date

Your spouse is the person to whom you are legally married during the plan year. A dependent is your child, stepchild under the age of 13 (*Dependent Care only*), handicapped spouse, parent, child, close relative, or a person who lives in your home, if you provide over half of his/her support and claim that person as an IRS dependent.

For Claims Information, Phone (503) 620-3822 (toll free) 1-800-452-0914



PO Box 23600
Tigard, OR 97281-3600