

OUTSIDE HEALTH INSURANCE REIMBURSEMENT FORM

Employee Information	
Name	Social Security Number
Company Name	

I certify that the following premium is for coverage during this Plan Year, and qualifies for payment under the Cafeteria Plan guidelines.

HEALTH INSURANCE PREMIUM INFORMATION	
NAME OF INSURANCE COMPANY	
INDIVIDUAL(S) COVERED BY POLICY	
POLICY NUMBER	
COVERAGE DATES FOR THIS PREMIUM PAYMENT	___ / ___ / ___ - ___ / ___ / ___
Total Amount of Reimbursement Requested	

(Please attach a copy of the premium and proof of payment)

I understand that because the above amounts are being paid with pre-tax dollars, they may not be claimed on my income tax return at the end of the year.

Employee Signature

Date

Change of address? No Yes New Address: _____



CDS Administrative Services, LLC
PO Box 570
Willmar, MN 56201
Phone: (888) 388-1040
Fax: (320) 235-0988
Email: benefits@cdscpa.com