CONTINUAL REIMBURSEMENT REQUEST FORM

EMPLOYER NAME:_____

PARTICIPANT NAME: _____

SOCIAL SECURITY NUMBER: _____

PARTICIPANT ADDRESS: _____

HOME PHONE: _____

WORK PHONE: _____

If charges incurred are for a dependent, DEPENDENT NAME:_____D.O.B:_____

Payment Information

FULLY DESCRIBE NATURE OF EXPENSE	TOTAL AMOUNT

TOTAL_____

Starting Date_____ Ending Date_____ No of Payment _____

Amount of each payment x_____

Total_____

Employer Agreement: As the Plan Administrator I agree to the above named participant in the _____125 Cafeteria Plan to be eligible to receive
(Company Name)
continual reimbursement based on the attached documentation for the above mentioned dates.

_____
Plan Administrator's

_____

(Employer) Signature Date

Participant Agreement: I verify that the information listed above and the information attached is true and correct. I understand that if any changes regarding the continual payments occur, that the Plan Administrator must be notified immediately. Failure to do so could result in additional taxes being applicable for which I would be responsible.

_____
Participants Signature Date

FOR CONTINUAL HEALTH CARE: This form must accompany an election form.

Rocky Mountain Administrators
809 South Railway Avenue / P.O. Box 788
Worland, WY 82401
Phone (307) 347-2606/ 800-383-8808 / Fax (307) 347-2646