

**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**

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