Section 125 Cafeteria Plan
Medical Reimbursement Request Form

Employer _____ Plan Year Start Date _____

First Name _____ MI _____ Last Name _____ SSN _____

Street Address _____ City _____ State _____ ZIP Code _____

Phone _____ Email _____

Instructions: Please utilize this form to request the reimbursement for eligible medical expenses under the Section 125 Cafeteria Plan. Please sign and date this form and submit to Bay Bridge Administrators (BBA) using the contact information at the bottom of this form.

	Type of Service (Office Co-pay, RX, etc.)	Date of Service	Name of person receiving service	Relationship if other than you	Total Expense
1.)				☐ Spouse ☐ Dependent	
2.)				☐ Spouse ☐ Dependent	
3.)				☐ Spouse ☐ Dependent	
4.)				☐ Spouse ☐ Dependent	
5.)				☐ Spouse ☐ Dependent	
6.)				☐ Spouse ☐ Dependent	
				Total:	

To the best of my knowledge and belief, my statements in this Medical Reimbursement Request Form are complete and true. I certify that the services described above were received on the dates indicated, that the expenses qualify as valid medical services under the Plan, and that I have not been reimbursed previously under the Plan or any other health plan, nor do I expect any of these expenses to be reimbursable elsewhere. If the reimbursement is requested for prescribed drugs, I certify that such drugs are not prescribed for cosmetic purposes. I understand that these expenses may not be used to claim any federal income tax deduction or credit. I also acknowledge that should the actual annual expenses claimed be less than the amount available, such balance shall remain with the employer at the end of the Plan year.

Employee Signature _____ Date

Bay Bridge Administrators, LLC., P.O. Box 161630, Austin, TX 78716
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Email: 125@bbadmin.com

BAY BRIDGE ADMINISTRATORS