

Keating & Associates, Inc

Claim Form

Name: _____ Social Security #: _____

Employer Name: _____ Change of Address: _____

Uninsured Medical Claim Information (Please complete.)

**Date of Service	**Person for whom Expense was incurred	**Name of Provider	**Description of Service	**Amount
1. ___/___/___	_____	_____	_____	\$ _____
2. ___/___/___	_____	_____	_____	\$ _____
3. ___/___/___	_____	_____	_____	\$ _____
4. ___/___/___	_____	_____	_____	\$ _____
5. ___/___/___	_____	_____	_____	\$ _____

Health Care Total \$ _____

Dependent Day Care Claim Information (Please complete.)

**From / To Service dates	**Qualifying individual for whom expense was incurred	**Daycare Provider (attach signed receipt)	**Amount
1. ___/___/___ -- ___/___/___	_____	_____	\$ _____
2. ___/___/___ -- ___/___/___	_____	_____	\$ _____
3. ___/___/___ -- ___/___/___	_____	_____	\$ _____

Dependent Day Care Total \$ _____

*Under penalties of perjury, I swear that the amounts indicated above are reimbursable to me, incurred by me during the plan year, paid by me during the plan year, and satisfy the requirements of the employee cafeteria benefit plan of _____.
(Your Company Name)

Date: _____

Employee Signature: _____

SEND COMPLETED FORM

AND RECEIPTS TO: Keating & Associates, Inc.
Cafeteria Department
1011 Poyntz Ave.
Manhattan, KS 66502
537-0366

CONTACT INFO:

claims@keatinginc.com
OR Fax: 785-537-0747 Local
Fax: 877-537-0747 Toll Free

****The receipt/statement must include: the amount incurred, description of service, the inclusive date(s) of service provided, name of service provider, and the name of the person the service was provided for.**