Trends International, LLC Salary Reduction Plan
REIMBURSEMENT REQUEST FORM

Participant Name _____ **Social Security #** _____

DEPENDENT CARE EXPENSE CLAIMS

Name of Dependent(s)	Period covered		Name & Address of Provider of Service	Taxpayer Identification # of Provider of Service	Amount Incurred
	From	To			
					$
(ATTACH RECEIPTS IN ORDER LISTED)			TOTAL DEPENDENT CARE EXPENSE		$

*NOTE The total amount claimed under the Plan for any coverage period must not exceed the lesser of your earned income for the plan year or the earned income of your spouse. If your spouse is either a full-time student or is incapable of taking care of himself or herself, then he or she is deemed to have monthly earnings of $200 if there is one child or dependent, and $400 if there are two or more. No payment may be made under the Plan if the service provider is your dependent for federal income tax purposes, or if your child or stepchild is under age 19.

MEDICAL EXPENSE CLAIMS

Date Exp. Incurred	Name of Service Provider	Expense Description	For Whom Expense Incurred	Net Amt
				$
(ATTACH RECEIPTS IN ORDER LISTED)		TOTAL MEDICAL CARE EXPENSE		$

READ CAREFULLY

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the Company's Cafeteria Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

_____ Participant's signature

_____ Date form submitted

_____ Daytime phone number

For administration use only:
Payment authorized $
File updated

For administration use only:
Date
Check number
$

CLAIM FILING INSTRUCTIONS

Who can file a Claim Form

- Only employees participating in the Cafeteria plan can file a reimbursement claim form.
- Participants can file a claim form during the plan year and up to March 31 following the plan year as described in the
- Summary Plan Description. (See Qualified Claims Below.)
- Terminated employees can file a claim form for a certain period after the date of termination if allowed by the Plan. Please see your Summary Plan Description.

What Expenses Can Be Claimed

- Only expenses incurred during the plan year can be claimed for reimbursement. Each year is treated separately and the year of claim is the year the expense was actually incurred by the participant.
- Terminated employees can request reimbursement for expenses incurred during the time period for which contributions were received. Please see your Summary Plan Description.
- Allowable expenses are the same as those allowed for tax purposes. A summary list is provided here for your convenience.

Qualifying Dependent Care Expenses

- Expenses paid to a dependent care center or care provider.
- Expenses paid for the care of a dependent under age 13.
- Expenses paid for care of other dependents who are physically or mentally incapable of caring for themselves.

Qualifying Unreimbursed Medical Expenses

- Only expenses **not** reimbursed by insurance can be claimed

-Ambulance hire
-Artificial limbs and teeth
-Automobile modifications (hand controls, special equipment, mechanical lifts)
-Braille books & magazines
-Crutches
-Drugs (legal) (prescription only or insulin) and medical supplies, qualified over the counter
-Elastic hose, medically prescribed
-Eyeglasses/contact lenses
- Fees
Acupuncture
Anesthetist
Blood donor
Chiropodist (expense)
Chiropractor
Christian Science practitioners
Clinic
Dentist
Diagnosis
Diathermy
Examination physical
Eye examination
Gynecologist
Healing services
Hospital
Laboratory
Lip reading lessons for the deaf
Medical Information plan
Midwife
Nurse
Obstetrician
Oculist
Ophthalmologist
Optician
Optometrist
Oral Surgery
Osteopath
Pediatrician
Physician
Physiotherapist
Podiatrist
Practical nurse
Psychiatrist
Psychoanalyst
Psychologist
Psychopathist
Sex therapist
Specialist
Surgeon
Therapy
-Halfway house residency
- Hearing devices
- Hospital bills
- Iron lung. operating cost
- Laetrile, when prescribed by doctor
- Nursing care
-Obstetrical expense
-Operations & related treatments
-Oxygen equipment
-Rental of medical or healing equipment
-Retirement home fees portion allocable to medical care
- Seeing-eye dog
- Special education
- Support or corrective devises (including special mattress and board for arthritis)
-Television set modification to receive closed captions
-Telephone for deaf
-Therapy treatments
-Transportation expenses relative to illness
-X-rays
-Wheelchair

Completion of the Claim Form

- Complete all information on the claim form for each amount claimed for reimbursement.
- Make sure the claim does not include items for more than one plan year. It is imperative to send <u>separate</u> claim forms for each year.
- You **must** sign and date the claim form.
- Attach a copy of a bill, invoice, or other written statement from a third party which supports each reimbursement request.

Complete the Reimbursement Claim Log

This form is for your use to record claims and payments related to this Cafeteria Plan. Enter the total amount of each claims in this log for your record.

How to Request changes in Plan Participation

- Revocation of participation in the Plan can **only** occur if you have a **change in family status**. "Change of family status" included birth, death, marriage, divorce, change of employment by the spouse or certain other situations as determined by the Plan Administrator.