Mail To: Administrative Services, Inc.
P. O. Box 590
Rochester, IL 62563

E-mail To: cafe@asi-tpa.com
Fax To: 217-498-8481

Company Name:_____

EDUCATIONAL ASSISTANCE CLAIM FORM

ID#:(first 4 last name - last 4 SS#) ___ ___ ___ ___ ___ ___ ___ ___ **Employee #:**_____

Participant's Name: _____
Last **First** **Middle**

To: Administrative Services, Inc.

The undersigned participant in the plan requests reimbursement (attach itemized bills, receipts and invoices, if available, for all expenses claimed) in the amounts shown below:

1. **Period Covered: From,**_____ **20**___ **Through,**_____ **20**__
2. **Name and address of Educational facility providing service and description of service:**

_____

_____

_____

*** Amount $**_____

***NOTE: The total amount claimed under the plan for any coverage period must not exceed the lesser of your wages or salary for the plan year.**

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 above company's plan with respect to such expenses. 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.

_____

Employee's Signature **Date**

For Plan Administrator use only: **Batch No:**_____
Payment Authorized_____ **Check No.**_____