

# JAG

## Section 125 Claim Form 2012

Send to: JAG, 343 Main Street, El Segundo, CA 90245

Fax to: 877-828-7319

**Participant Information**

Please check if this is a new address  Participant's Social Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Name: \_\_\_\_\_  
(Last) (First) (M.I.)

Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

**Medical, Dental, or Vision Insurance Premiums**

Provider Name	Coverage Period	Requested Amount of Reimbursement
Total		

When filing the claim forms for reimbursement under your (health, dental, and vision) insurance be sure to attach copies of statements from your insurance company, showing the date of premium and amount paid, a cancelled check, or credit card statement. Please note that this is for Monthly Medical, Dental and/or Vision Premiums only, this is **NOT** a Flexible Spending Account.

**Dependent/Child Care Claims** When claiming dependent care expense, please provide a written receipt of statement, including date and amount of expense incurred. (Handwritten receipts are acceptable for childcare.) Documentation will not be returned.

Effective January 1, 1989, the I.R.S. requires the dependent child care provider(s) to furnish the provider's current name, address, Tax Identification Number (or Social Security Number) to the tax payer making claim, unless the provider is exempt from federal income taxation as described in I.R.C. Section 501(c)(3). A provider failing to comply with this law is subject to \$50 fine for each such failure unless proven that failure is due to reasonable cause, not willful neglect.

The dependent care information including provider(s) name, address, TIN/SSN is correct to the best of my knowledge. I understand I may incur penalties of perjury if the information is knowingly misstated.

Name of Dependent Receiving Care	Age	Relationship	Provider Name & Address	TIN/SSN	Dates of Care	Requested Amount of Reimbursement

**Salary Reduction Agreement**

I have read and understand the explanation I have received regarding my options under the JAG Professional Services, Inc., Medical Benefit Plan. I understand I have the right to have the company make a deduction from my salary on a pretax basis during the plan year. I acknowledge that my election is irrevocable unless there is a change in my status. A change in status includes: marriage; divorce; death of a spouse or dependent; birth or adoption of a child; change in number of dependents; termination of employment or commencement of employment; commencement or return from an unpaid leave of absence; or any change in employment status that affects eligibility (a change in residence of you, your spouse or children; or your dependents either satisfies or ceases to satisfy requirements for coverage in age, student status, or any similar circumstances; or a change in your or your spouse's employment status).

I hereby apply for the options listed above. If necessary, I authorize JAG Professional Services, Inc. to adjust my pay as required by my elections. I understand that the benefit options I have elected will remain in force from January 1, 2012 until December 31, 2012 unless my family status or employment status changes.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date