TAXSAVER
PLAN
"Your Satisfaction Is Our Success"

Continuing Medical Education (CME) Claim Form

Please print

Name of Employer ______________________________ Social Security Number ______________

Employee Last Name ______________________________ First Name ______________________________

Mailing Address (Please request all address changes through your Employer) ______________________________

This is to certify that during the period of __/__/__ through __/__/__ I have incurred expenses in the amounts shown below that qualify for reimbursement under the provisions of this Plan.

- Medical Education Fees $ ______________________________
- Travel Expenses $ ____________________________________
- Professional Organization Dues $ ________________________
- Professional Books & Subscriptions $ _____________________
- Professional License Fees $ ____________________________
- Business Meals (submit 100%) $ _________________________
- Other – please describe and include percentages for business and personal use
- __________________________ (____% business; ____% personal) $ ____________________
- __________________________ (____% business; ____% personal) $ ____________________

Please note: Documentation of eligible medical education expenses must accompany claims for travel, lodging, and meals even if the medical education expense itself is not being claimed.

I further testify that I have attached records, receipts and canceled checks to this voucher to substantiate the above amounts, and that since these expenses are reimbursed by my employer, they will not be claimed on my income tax filings at year end.

___________ ____

Date Employee Signature

Submit Expenses To: Taxsaver Plan
P.O. Box 609002
Dallas, Texas 75360
800-328-4337 – www.taxsaverplan.com
214-528-8122 Fax
claims@taxsaverplan.com - attach tiff, jpeg or jif files. (please do not scan at a high resolution)