# OUT OF POCKET MEDICAL / DENTAL EXPENSE AGREEMENT FOR GAINESVILLE ISD

I have a medical / dental agreement with Dr. _____, TAX ID#/SS#_____, to provide_____ for _____ (name of patient). I pay $_____ a month for these services. This information is provided in conjunction with my employer's "OPTION 125" CAFETERIA PLAN. *Should my amounts change from that indicated above, I will inform my employer immediately*. Otherwise you may rely on the above information for issuing my monthly reimbursements for this service.

_____ _____

*EMPLOYEE SIGNATURE* *DATE*

***Reimbursements will not be issued without a completed contract & PROOF OF PAYMENT attached***