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Dependent Care
Reimbursement Claim Form

Note: Every item must be completed before claim can be processed! (please print in ink or type)

Employer/Plan Name: _____

Enrollee Name: _____ ID #: _____

Dependent Name(s): _____

_____

_____

Day Care Provider: _____ EIN or SS #: _____

Address: _____

City/State/Zip: _____

Dates of Services: _____ Through _____

Charge for Service: _____ Per Hr. _____ Per Day _____ Per Week _____

Total Charges: _____

_____
Day Care Provider Signature

Employee Certification

I certify that all items requested to be reimbursed comply with the Flexible Spending Account Plan and such items have not and will not be covered by any other plan or program of any employer or other person. I further certify that such items will not deducted or taken as tax credits on my personal federal and state income tax returns for any year. I understand this plan does not accept responsibility for direct payment to any individuals other than the employee.

_____ _____
Employee Signature Date