

# Dependent Care Reimbursement Request

Use This Form For Dependent Care Expenses Incurring  
September 1, 2005 through August 31, 2006

## FILING INFORMATION

- ◆ Attach a copy of the care provider's bill or a receipt from the care provider showing:
  - Name and address of the care provider;
  - The care provider's social security number or tax identification number;
  - The date(s) the care was incurred;
  - The amount charged for the care, itemized by day, if charge is not same per day.
- ◆ Sign this form and mail it, or send it through the Pony, to the address listed at the bottom of the form.
- ◆ You may not claim any amount reimbursed to you by the Plan as a deduction or credit on your Federal Tax Return.
- ◆ One Dependent Care Reimbursement Request Form may be used to file for multiple expenses.
- ◆ Minimum claim reimbursement is \$25.00. However, at the end of the Plan Year or at any other time when coverage is fully terminated, a claim can be made for less.
- ◆ You may want to keep a copy of your claim for your personal record.

REQUESTS FILED WITHOUT PROPER DOCUMENTATION WILL BE RETURNED FOR NECESSARY INFORMATION.

## CLAIM INFORMATION

(PLEASE PRINT OR TYPE)

Name of Employee: \_\_\_\_\_  
(Last) (First) (MI)

Social Security Number: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Eligible Dependent for Whom Care Was Provided:

\_\_\_\_\_  
(Last) (First) (Relationship) (Date of Birth)

Total Amount Requested: \_\_\_\_\_ Provider relationship to Employee, if any: \_\_\_\_\_

*To the best of my knowledge, my statements on this Request for Reimbursement are complete and true. I am solely responsible for the validity of claims submitted to my Flexible Spending Account. I am claiming reimbursement only for eligible expenses incurred during the Plan Year shown above. I certify that these expenses have not been reimbursed by any other source, nor will these expenses be reimbursed by any other source.*

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

\_\_\_\_\_  
*Date*



**Jefferson Federation of Teachers**  
**HEALTH AND WELFARE FUND**

POST OFFICE BOX 6137 • METAIRIE, LA 70009-6137

PHONE (504) 455-7261 • FAX (504) 455-7267

WWW.JFTHW.ORG