Dependent Care Reimbursement Request

Use This Form For Dependent Care Expenses Incurring
September 1, 2004 through August 31, 2005

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 $10.00. 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
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