



### Dependent Care Reimbursement Claim Form

Company: \_\_\_\_\_

Employee: \_\_\_\_\_  
Last First

SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
MM/DD/YY

Employee Email Address: \_\_\_\_\_

Dependent Name(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Day Care Provider: \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Dates of Services: \_\_\_\_\_ Through: \_\_\_\_\_

Charge for Service: \_\_\_\_\_ Per Hr. \_\_\_\_\_ Per Day \_\_\_\_\_ Per Week \_\_\_\_\_

Total Charges: \_\_\_\_\_

\_\_\_\_\_  
(Day Care Provider Signature or  
attach copy of provider receipt)

#### Employee Certification

I hereby certify that all items requested to be reimbursed comply with the Company's Flexible Spending Account 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 be deducted or taken as tax credits on my personal federal and state income tax returns for any year. The Company does not accept responsibility for direct payments to any individuals other than the employee.

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

\_\_\_\_\_  
Date