Clear Form

SCHOOL DISTRICT OF THE CITY OF ADRIAN

DEPENDENT CARE EXPENSE REIMBURSEMENT PLAN

REQUEST FOR REIMBURSEMENT FORM

Participant's Name:_____ Soc. Sec. #_____

Date of Service	Name of Individual for whom expense incurred	Relationship	Name of Provider	Amount of Expense

Total amount requested: $_____ 0.00

I represent that the information provided above and attached hereto is true and accurate, and that I incurred the expenses listed above on behalf of a dependent of mine. No part of this expense is reimbursable to me or my spouse or dependent under any insurance contract or under any other plan of this or any other employer of myself, my spouse, or my dependent. I agree to provide such additional information as the Plan Administrator may require.

Participant's signature:_____ Date:_____

Date received by Plan Administrator:_____ Initials:_____

ATTACH COPY OF ORIGINAL INVOICES/RECEIPTS.

Print Form

EMPLOYEE STATEMENT

I understand that in order to be entitled to a reimbursement for “Eligible Employment Related Expenses” under the Dependent Care Assistance Plan, I must deliver to the Plan Administrator proof of the incurrence of the “Eligible Employment Related Expense” for a qualifying dependent during the Plan Year, and provide the following information on the above page:

1. The qualifying dependent(s) for whom the dependent care services were rendered;

2. A description of the dependent care services;
3. The relationship to you, if any, of the person rendering the dependent care services;
4. If the services were rendered by a dependent of yours, the age of the dependent;
5. A description of where the dependent care services were rendered;
6. If the services were rendered outside of your home, a statement that (a) the day care center complies