



FLEXIBLE SPENDING ACCOUNT DEPENDENT CARE REIMBURSEMENT CLAIM FORM

EMPLOYER NAME: _____

EMPLOYEE NAME: _____

SSN: _____

EXPENSES FOR: _____

Name

Relationship to Employee

DEPENDENT CARE EXPENSES

DESCRIPTION OF ELIGIBLE EXPENSE	DATE EXPENSE INCURRED	NAME OF DEP. CARE PROVIDER	PROVIDER'S TAXPAYER ID#	REIMBURSEMENT AMOUNT DUE
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
TOTAL REIMBURSEMENT:				_____

I certify that the expenses for which reimbursement is requested under my employer's Dependent Care Assistance Plan have been paid by me. I will not use expenses reimbursed as deductions when filing my Federal Income Tax return. I authorize Self Funding Administrators to issue the amount requested above from my Dependent Care Assistance Plan in accordance with the terms and provisions of the Plan.

I understand that I am fully responsible for accurately identifying those expenses that qualify as eligible expenses and for any consequences should the Internal Revenue Service challenge the characterization of the payments made under the Plan.

I also understand that I am responsible for and liable to my employer for any reimbursement I may receive from my Medical Reimbursement Account in excess of my contributions to such account.

Signature

Date

**INSTRUCTIONS FOR COMPLETING
THE FLEXIBLE SPENDING ACCOUNT
DEPENDENT CARE REIMBURSEMENT CLAIM FORM**

Day Care Centers:

Required Documentation: Submit a completed Claim Form with a receipt from the Day Care Center which shows the amount of expense, dates of service, the name and federal tax ID # of the center.

Baby-sitters:

Required Documentation: Submit a completed Claim Form with a receipt from services which shows the amount of the expense, dates of service, the name and social security # of the baby-sitter.

1. Complete accurately all five columns of the Claim Form. Sign and date the Claim Form, attach copies of receipts and check for errors or omissions.
2. Make a copy of the Claim Form and attachments submitted for your records and mail to:

**Self Funding Administrators
Post Office Box 6596
Annapolis, Maryland 21401**

If you have any questions, please contact your Human Resources Department or Self Funding Administrators.