Dependent Care Reimbursement Account Claim Form

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Erskine College

Name:	Last	First	MI	SS#:
Address:	Street	City	State Zip	Daytime Phone Number:

Please read the Reimbursement Account Rules and Claim Filing Instructions before completing this claim

DEPENDENT CARE EXPENSE CLAIM

Dependent Name & Age	Relationship	Dates of Service	Provider Name EIN or SS#	Amount
Example: Joe Jones / 3 years old	Son	1/1/02 to 1/31/02	Miss Susie's Child Care 12-3456789	$400.00
1.		to		
2.		to		
3.		to		
4.		to		
5.		to		
6.		to		
7.		to		
			TOTAL AMOUNT REQUESTED	

<u>EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT</u>

I certify that the expense for reimbursement requested from my account was incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plan. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual tax return and agree to file IRS Form 2441 with my tax return. I also agree to notify my Employer if I have reason to believe that any expense(s) for which I have obtained reimbursement is not an Eligible Dependent Care Expense, and also agree on demand to indemnify and reimburse my Employer for any liability it may incur for failure to withhold federal and state income tax or Social Security tax for any reimbursement I receive for an expense which does **<u>not</u>** qualify as an Eligible Dependent Care Expense pursuant to IRS Publication 503.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature: ____ Date: _____/_____/_____