Reimbursement Claim Form

TOTAL # OF PAGES? ________________

# Dependent Care

## Company name:________________

Participants Name: ________________________________ Social Security # ________________________

Participants Address: ____________________________________________________________________

Day Time Phone #: ________________________________ Email Address: ________________________

Dates of Service: ____________________ to ______________________

Amount $ ______________________

Name and address of person or day care center providing service and description of services:
______________________________________________________________________
______________________________________________________________________

The undersigned participant in the plan requests reimbursement in the amounts shown above. Please attach receipts / bills from your daycare providers or include the daycare provider's signature on this form.

Provider's Tax ID # or SS# : ____________________ Provider's signature: ________________________

Note: The total amount claimed under the plan for any coverage period must not exceed the lesser of your wages or salary for the plan year of the wages or salary of your spouse. (If your spouse is either a full-time student or is incapable of taking care of himself or herself, then he or she is deemed to have a monthly earnings of $200.00 if there is one (1) child or dependent, and $400.00 if there are two (2) or more.) No payment may be made under the plan if the service provider is your dependent for federal income tax purposes, or is your child or stepchild and is under age 19.

READ CAREFULLY

The undersigned participant in the Plan **CERTIFIES** that all expenses for which reimbursement or payment is claimed by submission of this form, were incurred during a period while the undersigned was covered under the Plan with respect to such expenses. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for the payment of all related taxes including federal, state of city income tax on amounts paid from the Plan which related to such expense. The undersigned further understands that no dependent care tax credit is permitted for amounts for which reimbursement is made.

______________________________________________ ______________________

Employee's Signature Date

Send claims to:
American Benefit Services
P.O. Box 1635
Irmo, SC 29063
Fax : (830) 749-3621