Dependent Care Expense Reimbursement Form

Employer Company Name:_____________________________ Employee Name:_____________________________

Email or Home Phone:_____________________________ Social Security Number:_____________________________

Address:_____________________________ City:__________________State:_______Zip:___________

Dependent Name	Relationship	Date of Birth	Date of Care (From/To)	Name & Address of Provider/Facility*	Tax ID or Social Security #
____________	__________	_________	____________	______________________________	________________
____________	__________	_________	____________	______________________________	________________
____________	__________	_________	____________	______________________________	________________
____________	__________	_________	____________	______________________________	________________

If day care is provided by one of your children, please give that child's age____________. Amount of Reimbursement Requested $______________

Attach receipts, cancelled checks or bills.

I request reimbursement for the attached receipts under the Dependent Care Reimbursement Plan. I certify that these expenses are for my dependent's care as defined by the Internal Revenue Code. Furthermore, I declare that these expenses have not been reimbursed from any other source nor do I expect them to be.

Employee's Signature___________________________________ Date_________________

Fax is the preferred means of claims submission. You may also email or mail this form (with your documentation) to:

Cafeteria Plan Company
PO Box 3684
Corrales, NM 87048
Phone: 505-822-9300
fax: 505-247-0568 or 1-866-207-3916
email: kkoss@rsabq.com