



Dependent/Child care Spending Account  
 Request for Reimbursement  
 Plan No. 501

Cafeteria Spending Account

Employee \_\_\_\_\_

Client Company \_\_\_\_\_

(Please use this form to request reimbursement for Dependent/Child care expenses only)

Provider of Services	Person Receiving Services	Relationship	Date Expenses Incurred	For Office Use	Reimbursement Request Amount

Total Reimbursement Requested \$ \_\_\_\_\_

**CLAIMS RECEIVED AFTER THE 20<sup>TH</sup> OF THE MONTH WILL BE PAID THE FOLLOWING MONTH.**

I certify that:

1. The dependent care expenses claimed above enable me to be gainfully employed, are attributable to the care of a qualifying individual, and have not been paid to a dependent. I further certify that these dependent care expenses submitted under this claim and when combined with dependent care expenses reimbursed previously this year do not exceed my (or, if married, my or my spouses) earned income.
2. The expenses claimed above have not been and will not be taken as a credit or deduction on my personal income tax return.
3. Where I have not included the address and taxpayer identification number or each dependent care provider listed above, I have done so because of one of the following reasons:
  - I submitted it earlier this year.
  - The provider is a non-profit, religious, charitable or education organization (under Code Section 501(c)(3)).
  - I was unable to obtain this information after diligently trying to obtain it.

Date \_\_\_\_\_

Employee Signature \_\_\_\_\_

## Instructions for Completing Claim Form

To prevent delays in processing your claim, Please complete this form correctly.

1. **Employee Name and Social Security Number:**  
In the space provided, print or type your name as it appears on the payroll records and enter your correct Social Security Number.
2. **Provider of Services:**  
Enter the name of the person or facility that provided the service. Use a separate line for each expense.
3. **Person Receiving Service:**  
Enter the dependent's name.
4. **Relationship:**  
Enter the dependent's relationship to you; for example, spouse or child.
5. **Date Expense Incurred:**  
Enter the date the expense was incurred, not the date it was paid.
6. **Reimbursement Request Amount:**  
Enter the amount of the incurred expense that is eligible for reimbursement.
7. **Total Reimbursement Requested:**  
Add amounts of reimbursement requested and enter the total.
8. **Date and Employee Signature:**  
Enter the date and sign the form.
9. **Documentation Needed:**  
You must attach copies of required documentation to receive reimbursement.
  - For dependent care expenses, attach a statement of expenses from the provider showing the dependent's name, the incurred date and the amount of expenses. Include the provider's name, address, and social security number or taxpayer identification number on the first claim submitted for that provider each year. Note that the provider may be subject to penalty for not providing this information to you.
10. **Send completed form with documentation attached to:**

Aabakus, Inc. 750 Old Hickory Blvd. Suite ONE-275 - Brentwood, TN 37027.