DEPENDENT CARE EXPENSE CLAIM FORM

City of Richardson

Participant Name _____ **Date** _____

Social Security No _____ **Employee No.** _____

I am a participant in the *Flexible Benefits Plan* and request reimbursement (attach itemized paid bills, receipts, invoices or have care provider sign below for all expenses claimed) for the amounts shown below:

1. Name of Dependent: _____

2. Period covered from: _____/_____/_____ through _____/_____/_____
   month/day/year month/day/year

3. Name, address and **social security or tax ID number** of person providing services:

Name Address:

Social Security # or Tax ID number of provider:

Signature of Care Provider Date Signed Amount $

NOTE:

A. The total amount claimed under the Plan for any coverage period must not exceed the lesser of one-half of your wages or salary for the Plan year, or the wages or salary of your spouse.
B. No payment will be made under the Plan if the service provider is your spouse, eligible child, or other person for whom you or your spouse are entitled to take a dependent deduction on your federal tax return.

To the best of my knowledge and belief, my statements in this Reimbursement Request Form are complete and true. I have read, understand and make the certifications contained in the Certificate of Qualifying Dependent Care Expenses. I understand that these dependent care expenses may not be used to claim any federal income tax deduction or credit (including the dependent care tax credit). I agree to File IRS Form 2441 with my tax return and provide any taxpayer identification number required thereon. I authorize a reduction in my Dependent Care Assistance Account in the amount of the reimbursement. I certify that I have not sought reimbursement previously for this same expense.

_____
Signature

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PLEASE MAIL CLAIMS TO:

The EPOCH Group
Attention: FLEX Department
P.O. Box 9030
Shawnee Mission, KS 66201-1630