EMPLOYEES' FLEXIBLE BENEFITS PROGRAM

EXPENSE REIMBURSEMENT FORM – *DEPENDENT CARE* SPENDING ACCOUNT

(Use this form ***only*** for qualified Dependent Care expenses.)

Employer Name:____

(Please print or type)

Employee Name:____

(Please print or type)

Social Security Number: ______ - _____ - ______

Dependent's Name:_____________________________Relationship:________________

CLAIM INFORMATION

Date(s) of Service: _____/_____/_____ to _____/_____/_____

Provider's Name: ____

(Name of dependent care provider)

Provider's Address: ____

____

Total Cost of Services To Be Reimbursed: $___________________________

In submitting this claim, I certify that the following statements are true:

- The expense incurred enables my spouse (if applicable) and me to be gainfully employed (or, if my spouse is not employed, is in active search of employment, a full-time student, or incapable of self-care).
- The primary purpose of the care is custodial in nature (for the well-being and protection of the individual(s)), not primarily for other purposes such as education, overnight camp, etc.
- These expenses have not been reimbursed and are not reimbursable under any other plan.
- Neither the dependent care tax credit nor any other credit have been or will be claimed for the same expenses I am submitting for reimbursement under this plan.

Signature of Employee ______________________________________*Date* ______________

I ________________________ , as provider (or administrator of the above named provider) certify that the above information is correct and have rendered services for the above listed dependent (s) for the dates listed and the amount stated.

________________________	________________________	________________
Signature	*Tax ID # or SS#*	*Date*

SUBMIT CLAIM TO: GMR Administrative Services
PO Box 24369
Rochester, NY 14624-0369
(800) 724-4817 Fax (585) 426-6981