

# DEPENDENT CARE REIMBURSEMENT EXPENSE CLAIM FORM

## Cafeteria Section 125 Plan

PLEASE PRINT

EMPLOYEE SOCIAL SECURITY NUMBER

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Employee Name: \_\_\_\_\_

Employer: \_\_\_\_\_

**The following must be provided to ensure processing of your claim:**

1. A receipt with the name, address, taxpayer I.D. # of the service provider, and the dates of service; along with a claim form signed by you stating the amount you are requesting for reimbursement. (If due diligence is used to obtain the tax I.D. number and it is unobtainable, Freedom One Retirement Services will still process the claim)
2. In the event that a receipt is not available, fill in the necessary information on this form in the space provided and have your care provider sign this form.
3. Documentation will not be returned. Please remember to make copies of everything submitted for your records.

Name of Dependent Care Provider: \_\_\_\_\_

Address of Provider: \_\_\_\_\_

Provider's Taxpayer I.D. #: \_\_\_\_\_

Name of Dependent(s)	DATE OF SERVICE		Amount
	From	To	
<b>Total Amount to be Reimbursed</b>			<b>\$</b>

**Signature of Dependent Care Provider:** \_\_\_\_\_

**Verification Statement:** I verify that the above information is true and correct and that the expenses claimed above are proper expenses under the plan. In the event these are not proper expenses under the plan, I understand that I am liable for additional taxes that would be applicable.

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

\_\_\_\_\_  
Date

If you **DO NOT** have a third party receipt, your claim will not be reimbursed unless your daycare provider has signed this form.

**THIS SECTION TO BE COMPLETED BY FREEDOM ONE RETIREMENT SERVICES**

Date Paid: \_\_\_\_\_

Amount Paid: \_\_\_\_\_

Completed by: \_\_\_\_\_

