REQUEST FOR REIMBURSEMENT
SECTION 125 CAFETERIA PLAN
DEPENDENT CARE/CHILD CARE EXPENSE FORM

SEND YOUR COMPLETED REQUEST FOR REIMBURSMENT FORM (WITH SUPPORTING DOCUMENTATION) TO:

ASSOCIATED BENEFITS CORPORATION
1415 28th STREET, SUITE 100
WEST DES MOINES, IA 50266-1450
Phone 515-226-0303 or 800-747-4421
Fax: 515-226-8472

USE THIS FORM WHEN:

- **REQUESTING REIMBURSEMENT FOR DEPENDENT CARE/CHILD CARE EXPENSES.**

PLEASE NOTE: THIS IS NOT A MEDICAL EXPENSE REIMBURSEMENT FORM.

EMPLOYEE INFORMATION

Name	Social Security Number		Group #
Home Address	City	State	Zip
Employer	Employer City	Work Phone	

DEPENDENT CARE / CHILD CARE ACCOUNT

	DEPENDENT RECEIVING CARE NAME	RELATIONSHIP	DATE(S) OF SERVICE	DEPENDENT CARE/CHILD CARE PROVIDER INFORMATION	AMOUNT REQUESTED
1.				**Name**	
2.				**Street**	
3.				**City, State, Zip**	
4.				**Social Security or Tax ID#**	
5.				***NOTE: BE SURE TO INCLUDE THE TAX ID NUMBER OR SOCIAL SECURITY NUMBER IN THE BOX ABOVE***	

TOTAL DEPENDENT CARE/CHILD CARE EXPENSES REQUESTED: $

***Expenses that have been paid will not be reimbursed until after they have been incurred.**

I CERTIFY THAT THE EXPENSES SHOWN ARE VALID:

X _____ _____

SIGNATURE OF DEPENDENT CARE/CHILD CARE PROVIDER* **DATE SIGNED***

*** DEPENDENT CARE/CHILD CARE PROVIDER MUST SIGN AND DATE FORM**

EMPLOYEE CERTIFICATION—Reimbursement cannot be paid without your signature on this form.

I request reimbursement from the Employee Dependent Care/Child Care Reimbursement Account for the expenses itemized above. I certify that these expenses are not eligible for reimbursement from any other source. I understand that these expenses must qualify for reimbursement under the Internal Revenue Code. I also understand that reimbursed expenses cannot be claimed as credits or deductions on my personal income tax return. The information on the Request for Reimbursement is true and correct to the best of my knowledge.

I certify that I am the custodial parent of the dependents listed above.

I certify that I am not claiming expenses for time when my spouse and I were not actively at work.

EMPLOYEE SIGNATURE _____ **DATE** _____