DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT REQUEST FOR REIMBURSEMENT

Company Name:_____

I. Participant Name: _____
(Please print or type)

Social Security Number:_____-_____- _____

II. Invoices attached
(Please attach a separate sheet if more space is needed)

Date of Service	Child Care Facility Name	Tax ID	Amount
_____	_____	_____	$_____.__
_____	_____	_____	$_____.__
_____	_____	_____	$_____.__
_____	_____	_____	$_____.__

III. Total Amount Requested $_____.__

IV. Statement by Participant
The dependent care expenses hereby presented for reimbursement from the Plan have not been reimbursed and will not be reimbursed through any other dependent care plan, including other dependent care flexible spending arrangements.

_____ _____
Participant's Signature Date

For Administrative use only

Reviewed by: _____ Date: _____
Plan code: _____ Employee number: _____
Plan Year: ___ Benefit code: _____

Approval
Trans. type: ____ As of: / /___ Approved: $_____.___

Denial
Trans. type: ____ As of: / /___ Denied: $_____.___

Reason for Denial: _____

Action to be taken:_____

P.O. Box 7
Fort Edward NY 12828
Phone: 518-338-3500
Fax: 518-338-3502

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT
REIMBURSEMENT REQUEST FORM

Explanation to Participants

To submit a request for reimbursement, you must complete this form, sign it and attach the documentation needed to verify that your expenses are qualified for reimbursement under the Plan. Return the completed form, with the documentation, attached to your Benefits Coordinator.

**** Invoices Attached ****
Please list the invoices or statements which are attached. These documents must be issued by the third parties who provided the dependent care and must show the name and tax identification number of the provider, the dates that services were provided, and the amounts charged for the services.

In general, the types of expenses for dependent care services which can be reimbursed by the Plan are the same types of expenses which the Internal Revenue Service would consider for the dependent care tax credit as employment-related expenses under Internal Revenue Section 21(b)(2). Please refer to the Summary Plan Description and the Plan document for a more complete explanation of qualified expenses.

Expenses must be for services that you received during the same period that you make deposits into your dependent care reimbursement account. And, you cannot ask the plan to reimburse you in advance. For example, if you start deposits with the pay period that begins on February 1, on February 2 you can submit a claim for child care given on February 1, but not for care given on January 31 or for care to be given in March.

**** Total Amount Requested ****
Please enter the total amount that you are requesting for reimbursement, based on the documentation you have attached.

If your expenses qualify for reimbursement from the Plan, you will be reimbursed for the total of your expenses, but not more than your account balance in the Plan. Your account balance is the total of the deposits you've made into your Dependent Care Flexible Spending Account minus the reimbursements you've received for the Plan Year.

**** Statement by Participant and Signature ****
Besides providing the information that is needed to prove that your claim is qualified for reimbursement, you must sign the form, swearing that you have not and will not submit these expenses for reimbursement from another Plan. For example, if you are covered by more than one dependent care plan, you cannot receive a reimbursement from this Plan and from the other Plan, too.