04 - 05 REIMBURSEMENT CLAIM FORM

EMPLOYEE NAME:__________________________________ **SS #**____________________

A. EXPENSE DOCUMENTATION

Claims must be incurred during the current plan year. Bills must be paid before they can be reimbursed. This plan may reimburse an eligible expense only if the participant provides a claim form with supporting documentation as follows:

- Fully itemized bill(s) including dates of service, name of claimant, type of service, amount of expense incurred, provider name, provider address and provider tax identification number.
- Employees may not submit proof of payment in the form of a cancelled check unless it is accompanied by the other required documentation.

1. Date of Service	Payment made to	Service Provided	Amount Paid
Person Service Provided for	Relationship	Date of Birth	
2. Date of Service	Payment made to	Service Provided	Amount Paid
Person Service Provided for	Relationship	Date of Birth	
3. Date of Service	Payment made to	Service Provided	Amount Paid
Person Service Provided for	Relationship	Date of Birth	
4. Date of Service	Payment made to	Service Provided	Amount Paid
Person Service Provided for	Relationship	Date of Birth	
		$	TotalAmount

B. OTHER DEPENDENT CARE INFORMATION

Dependent Care Provider Name & Address	Tax ID # or Soc. Sec. No.	Provider would not supply TIN/SSN

C. EMPLOYEE CERTIFICATION

I certify that the expenses listed above qualify for reimbursement under the Tax Saver Flexible Benefits Plan and have incurred and paid by me. These expenses claimed for reimbursement have not been reimbursed by my health care plan or any other health care plan. In claiming reimbursement for dependent care expenses, I certify that my spouse and I WILL NOT receive reimbursements in excess of $5,000 from all employer-sponsored dependent care spending account plans and that the service provider is not a child of mine under the age of 19 and is not otherwise a person who can be claimed by my spouse or by me as a dependent for federal income tax purposes. I understand that I am responsible for using my account(s) properly and for complying with all IRS regulations.

Signature ______________________________________ Date ________________________

FOR HUMAN RESOURCES USE ONLY	CLAIM #:	DATE ENTERED: