Dependent Care Reimbursement Claim Form

PITTMAN & ASSOCIATES, INC.

EMPLOYEE INFORMATION ***(Please Print)*****:** ☐ Check here if address has changed

Name: _____ **SSN:** _____

Address: _____ **Day Phone:** _____

City, State, Zip: _____ **email address:** _____

Employer: **CUMBERLAND HEIGHTS FOUNDATIONS, INC.** **Group Number:** **HRA954**

Receipts/Documentation should include the following information:
(Attach supporting documentation)

☐ Name of Provider
☐ Provider's Address & Tax ID #
☐ Date(s) of Service
☐ Service Provided
☐ Amount Billed
☐ Name(s) of dependents & ages

The undersigned participant in the plan requests reimbursement (attach itemized bills, receipts and invoices for all expenses claimed) in the amounts shown below. If additional space is needed please use the back of form. Name and address of the individual or center where dependent care expenses were paid.

Provider Name: _____ Expense Amount: _____

Address: _____ Tax ID or SS#: _____

Name of Dependent: _____ Age: _____

Name of Dependent: _____ Age: _____

Name of Dependent: _____ Age: _____

Total Expense Amount: $_____

Dependent Care reimbursement policy is according to IRS regulations.

Employees may submit claims early but they will be kept "pending" until the account has been funded by payroll deductions. All Dependent Care reimbursements are by check through regular mail. (direct deposit is not an option)

Contact your Benefits Representative if you have questions.
Benefits Administrator for Cumberland Heights Foundation, Inc:

Susan Newkirk
The Crichton Group
(615) 687-2840 phone / snewkirk@cbjw.net

Read Carefully:

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the Plan with respect to such. The undersigned fully understands that he or she alone is responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed or a proper expense which was incurred during the current plan year, the undersigned may be liable for payment of all related expenses including federal, state, or city income tax on amounts paid from the Plan which relate to such expenses.

Employee's Signature _____ Date: _____

MAIL or FAX to (901) 473-3266
Pittman & Associates, Inc. / Attn: HRA/FSA Department / P.O. Box 111047 / Memphis, Tennessee 38111