Dependent Care Reimbursement Claim Form

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

Name: _____ **SSN:** _____

Address: _____ **Day Phone:** _____

City, State, Zip: _____ **Email Address:**_____

Employer: **CUMBERLAND HEIGHTS FOUNDATION** **Group Number:** **HRA954**

The undersigned participant in the plan requests reimbursement and has attached 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.

Dependent(s) Name	Age	Period Covered From	To	Name, Address and Taxpayer Identification Number of Provider of Service	Amount Incurred
					$
					$
					$
					$
					$
				*TOTAL DEPENDENT CARE EXPENSE CLAIM	$

Note: The total amount claimed under the Plan for any coverage period must not exceed the lesser of your earned income for the plan year or the earned income of your spouse. (If your spouse is either a full-time student or is incapable of taking care of himself or herself, then he or she is deemed to have monthly earnings of $200 if there is one (1) child or dependent and $400 if there are two (2) or more.) No payment may be made under the Plan if the service provider is your dependent for federal income tax purposes, or is your child or stepchild and is under age 19.

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:
HealthSmart Benefit Solutions / Attn: HRA/FSA Department / P.O. Box 111047 / Memphis, Tennessee 38111
(901) 473-3349 / (800) 238-1344 / Fax: (901) 473-3266