REQUEST FOR REIMBURSEMENT UNDER THE DEPENDENT CARE ASSISTANCE PLAN

The following information is provided regarding the expenses which I would like to have reimbursed to me under the Dependent Care Assistance Plan. Attached are receipts, bills, canceled checks, vouchers, or other proof which verify these expenses.

My Name: _____.

Name(s) and Age(s) of Dependents, and Relationship of each Dependent to me.

_____ _____

_____ _____

_____ _____

*Amount of Expenses: $*_____

*Description of Expenses:*_____

_____

_____.

Information Regarding Dependent Care Provider:

A. Name, address, tax identification number of provider.

_____

_____

*Social Security or Tax I.D. Number:*_____

B. Provider is my child: { } Yes { }No

C. If provider is my child: Age: _____ Full time student { }Yes { }No

Where Services Were Performed:

A. Inside home: *{ }Yes* *{ }No*

B. Outside home: *{ }Yes* *{ }No*

1. *If yes, is dependent under age 13?* *{ }Yes* *{ }No*

2. *Dependent regularly spend at least eight hours per day. { }Yes { }No*

C. If expenses were incurred with respect to a day care center:

1. *Day care center complies with all applicable state and local gov't laws and regulations. (Copies of the day care center's state and local licenses are attached).* *{ }Yes { }No*

2. *Day care center provides care for more than six persons, other than persons residing at the center.* *{ }Yes { }No*

3. *Amount of fees paid to the day care center.* *$_____*

Marital Status:

A. Single { } *Married { }*

B. Dependent care expenses do not exceed the lesser of your salary or your spouse's salary or wages. [Note: If your spouse is incapacitated or is a full-time student, special rules apply for determining the amount of your spouse's salary or wages. See Summary Plan Description for the Dependent Care Assistance Plan for more information.] *{ }Yes { }No*

I hear by state that the expenses described are true and valid, were incurred during the Plan Year beginning January 1, 2015 and ending December 31, 2015 and are not otherwise reimbursable, and that no deduction or tax credit has been or will be taken by me on my Federal income tax return with respect to any of these expenses.

_____ _____

Date *Signature of Employee*