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DEPENDENT CARE ASSISTANCE EXPENSES
 REIMBURSEMENT REQUEST FORM

Employer Name Mannheim School District 83		Branch Location		Group No. A05100
Employee's Last Name		First	M.I.	Birth Date (Mo./Day/Yr.)
Street Address		City	State	Zip Code
Social Security No.		Telephone No.:		Sex: ? Male ? Female
Dependent Care Expenses				
Dependent Name(s)		Relationship		Age
1. _____		_____		_____
2. _____		_____		_____
3. _____		_____		_____
Dependent Care Provider Name				
Street Address _____				
City _____		State _____		Zip _____
Tax I.D. or Social Security No. _____				
Dates of Care		Amounts		
_____		\$ _____		
_____		\$ _____		
TOTAL AMOUNT REQUESTED		\$ _____		
Provider's Signature (or attach receipt): _____				
Date: _____				
Is Provider of Service related to dependent? ? Yes ? No. If yes, please list age and relationship of provider: Age: _____ Relationship: _____				
I certify that the expenses listed above qualify for reimbursement and have been incurred and paid by me or by eligible members of my family. In claiming reimbursement for dependent care expenses, I certify that my spouse and I WILL NOT receive reimbursement in excess of \$5,000 from all employer sponsored dependent care accounts.				
Participant's Signature: _____ Date: _____				