FLEXIBLE BENEFIT PLAN
REIMBURSEMENT CLAIM FORM
DEPENDENT CARE

- Use mouse or tab key to move to next field in form
- Requests must be turned in by the15th of the month, in order to be paid by the 25th

Randolph College

Participant's Name: _____
Last *First* *Middle*

DEPENDENT CARE EXPENSE				
Name of Dependent(s)	**Period Covered From**	**To**	**Name, Address & Taxpayer Identification No. Of Service Provider**	**Amount Incurred**
				$
				$
				$
				$
Attach a receipt from your daycare provider			***Total Dependent Care Expense**	$

***NOTE:** The total amount claimed under the Plan for any coverage period must not exceed the lesser of your wages or salary for the Plan Year or the wages or salary 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 Randolph College Flexible Benefit Plan with respect to such expenses and that such expenses have not been reimbursed, or are not reimbursable, under any other health plan coverage. **The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is produced by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid from the Plan which relate to such expense.** The undersigned further understands that no dependent care tax credit is permitted for amount for which reimbursement is made.

_____ _____
Employee's Signature Date