UTAH SCHOOL BOARDS ASSOCIATION
860 East 9085 South * Sandy, Utah 84094
801-566-1207 * Fax 801-561-4579

DEPENDENT CARE REIMBURSEMENT REQUEST

EMPLOYEE INFORMATION

(Please Print - Last, First, MI) | Daytime Phone Number | Employee Soc. Sec. No.

Employee Home Address | City | State | Zip Code

DEPENDENT CARE EXPENSES

Dependent's Full Name	Birth Date	Date of Service From – To	Reimbursement Request Amount
1.			
2.			
3.			

____ **TOTAL $**__________________

Provider's Name and Address (Please have provider fill out the Affidavit below)

AFFIDAVIT OF DEPENDENT CARE SERVICES RENDERED

I have provided adult/child care for ________________________________ for the period beginning _________________
and ending ______________. Services were provided to ____________________________ for a fee of $______________
Signature of Care Giver _______________________________ Tax ID # or SS# _________________ Date ___________

DEPENDENT CARE EXPENSES

Dependent's Full Name	Birth Date	Date of Service From – To	Reimbursement Request Amount
1.			
2.			
3.			

AFFIDAVIT OF DEPENDENT CARE SERVICES RENDERED

I have provided adult/child care for ________________________________ for the period beginning _________________
and ending ______________. Services were provided to ____________________________ for a fee of $______________
Signature of Care Giver _______________________________ Tax ID # or SS# _________________ Date ___________

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I hereby authorize release of payment through my Flexible Spending Account(s). I hereby authorize your company or its representatives to obtain necessary information from all physicians, hospitals, medical service providers, dependent care providers, pharmacists, employers, and all other agencies or organizations (this includes other insurers) to consider the claim for reimbursement under my Flexible Spending Account(s).

To the best of my knowledge and belief, my statements in this request for reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year for myself and/or my legal dependent(s). I certify that these expenses have not previously been reimbursed, nor will they be reimbursed under any other benefit plan and will not be claimed as an income tax deduction.

Employee's Signature ______________________________ **Date** ____________________

PLEASE attach appropriate RECEIPTS to support your claim