DEPENDENT CARE REIMBURSEMENT CLAIM FORM

Employer | Your Phone # (no dashes)

Name | SSN (no dashes)

Address

City | State | Zip Code

TO CLAIM REIMBURSEMENT ON ELIGIBLE EXPENSES:
Submit documentation that clearly gives the following information:

1. Name of Dependent Care Provider
2. Name of person(s) receiving dependent care.
3. Dates for which service was provided.
4. Amount charged.
5. Evidence that payment has been made by the claimant.

-Fill in the Lines below, sign you name and attach all required documentation.
-Label documentation to correspond with the appropriate line number.
-KEEP A COPY FOR YOUR RECORDS and mail the original with all documentation to:

FORMULA CORPORATION
Dependent Care Reimbursement
2919 Eagandale Blvd., Suite 120
Eagan MN 55121
Fax: 651-686-0513

If you have any questions please call 651-686-0108 or toll free 888-686-0412.

Line	Dependent Care Provider Name	Person Receiving Dependent Care Service	Date of Service	Amount Paid
1				
2				
3				
4				
5				
6				
7				

TOTAL PAID

I hereby certify that the information above is true and correct, and that neither I, my spouse, nor any of my eligible dependents have or will receive reimbursement for any of the expenses listed above from any other source, and furthermore, that I have not, and will not, claim any of these expenses as a deduction on, or in calculating a credit from my/my spouse's income taxes. In addition, I certify that the "Person Receiving Services" listed above is eligible to be covered under the Plan.

Date

Signature

Print Form