

Section 125 Flexible Benefit Plan

**DEPENDENT CARE REIMBURSEMENT REQUEST**

*"Please Print"*

Name of Employee:	SSN: (required)     -     -
Address:	Address Change: <input type="checkbox"/> Yes <input type="checkbox"/> No
City/State/Zip:	Email Address:

**Expense Information - Please Print**

Please provide the following information for each expense for which you are requesting reimbursement. In order to be eligible for reimbursement, the expense(s) must have been incurred for the care of one or more qualifying individuals **and** both you and your spouse must be either employed or a full time student at the time the care was provided. The provider information section must be completed and signed by the provider **OR** if your provider is unable to sign, a statement or receipt from your provider which reflects the date(s) of service - not just payment date - must be attached.

<u>Dates of Service</u>	<u>Amount Requested</u>	<u>Dependent Name</u>	<u>Dependent Age</u>
___/___/___ to ___/___/___	\$ _____	_____	_____
___/___/___ to ___/___/___	\$ _____	_____	_____
___/___/___ to ___/___/___	\$ _____	_____	_____
___/___/___ to ___/___/___	\$ _____	_____	_____
<b><u>Total Amount Requested</u></b>	\$ _____	<u>only those expenses incurred prior to the date of this request will be processed</u>	
<b><u>Provider Name (please print)</u></b>	<b><u>Provider Tax ID</u></b>	<b><u>Provider Signature</u></b>	
_____	_____	_____	

**Participant Acknowledgement:** Reimbursements will only be made for expenses incurred **prior** to the date of the Reimbursement Request. An expense is considered to be **incurred** when the service is provided **not** when you make payment to your provider. Reimbursements will only be made when accumulated claims exceed \$25.00. The \$25.00 requirement is waived at the end of the plan year. All payments and correspondence will be issued directly to you. Receipts and/or statements **must** include **date of service, itemization of service, provider of service, amount charged, and age of child**. I hereby certify that this information is, to the best of my knowledge, correct and that I have not or will not be reimbursed by any other plan or program nor will the expense(s) be used as a basis for the tax credit. I also certify that the expense(s) were incurred for care of dependents 12 years or younger unless required due to physical or mental handicap. Claim documentation cannot be returned – please keep copies for your records.

**Employee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



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