# Claim For Reimbursement

Name: ____________________________________________

Employer: ______________________________

**DEPENDENT CARE EXPENSE CLAIMS**

| Name of Dependent(s) | Period Covered From | Period Covered To | Name, Address and Taxpayer Identification Number of Provider of Services | Amount Incurred |
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| ***TOTAL DEPENDENT CARE EXPENSE CLAIM** | | | | |

* NOTE: The total amount claimed under the Plan for any coverage period must not exceed the lesser of your earned income for the plan year or the earned income 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.

For Dependent Care Expenses you may choose to have your dependent care provider sign and date below to certify the expenses were incurred, in lieu of providing a separate dependent care receipt.

I certify that the dependent care expenses shown above are valid:

Dependent Care Provider Signature ____________ Dependent Care Provider Social Security No. / Tax ID ____________ Date ____________

**READ CAREFULLY:**

The above is a true and accurate statement of unreimbursed medical and/or dependent care expenses incurred by me or my eligible dependents on the date(s) indicated, and were incurred while I was covered under the Company's Cafeteria Plan. I have submitted any medical expenses covered by other medical plan(s) to those plans, but payment has been denied in full or in part, as shown on the attached form. Receipts from my service provider(s) for all expenses are attached to this voucher. I understand that I can not claim any reimbursed expenses on my Income tax return, and that I may be liable for payment of all related taxes including Federal, State, or City income tax on the amounts paid for any expense improperly claimed under the Plan.

Signature: ______________________________ Date: ________________

Please send claims to: J. Peat & Associates, Inc.
20 Blake Avenue
Lynbrook, NY 11563-2506
Tel: (516) 599-2120
Fax: (516) 599-8310

claims@benefitcoverage.com