Dependent Care Assistance Program
Reimbursement Form

Employer Name:______________________________

Your Name:______________________________ Social Security Number:________________

Address:____________________________________ City:______________________ State:_____ Zip:____________

Email:_________________________________ Phone:________________

Dependent Name	Relationship	Birth Date	Dates of Care (To/From)	Name & Address of Provider or Facility *	Tax ID or Social Security Number

Amount of Reimbursement Requested $____________ (Attach receipts, cancelled checks, or bills.)

* If day care is provided by one of your other children, please give that child's age______.

I request reimbursement for the attached receipts under the Dependent Care Reimbursement Plan. I certify that these expenses are for my dependent's care as defined by the Internal Revenue Code. Furthermore, I declare that these expenses have not been reimbursed from any other source nor do I expect them to be.

Employee's Signature________________________________ Date___________________

SUBMIT TO: The Cafeteria Plan Company
500 4th Street NW Suite 301
Albuquerque, NM 87102 **or FAX to: 505-247-0568**