

Flexible Spending Account Dependent Care Claim Form

Submit this form to: Employee Benefits Suite 100 Donhowe 319 15 th Ave. SE Minneapolis, MN 55455	U Wide Form UM 1507 Rev: 11/05
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Instructions: Complete all sections of this form. Remember to sign and date the form and to include your Employee ID. Submit this form with the signature of your dependent care provider OR documentation verifying eligible expenses incurred. Keep a photocopy for your records. If you have questions, call 612-624-9090, option 3, or 1-800-756-2363.

Reimbursement Process: If you are enrolled in payroll direct deposit, your reimbursement check will be deposited into the same bank account. Otherwise, checks will be mailed to your home address.

Employee Name (Last, First)		Day Phone		Employee ID
Street Address	City	State	Zip	These expenses have been incurred during calendar year:

	Dates of Service		Amount of Reimbursable Expense	Dependent Information			Dependent Care Provider Information (Required)	
	From	To		Name	Date of Birth	Relationship to Employee	Name	Social Security or Tax ID Number
1								
2								
3								
4								
5								
	Total:							

Dependent Care Provider Receipt: I acknowledge that the dependent care expenses described above have been incurred and that I have received payment for these services.

Signature of Dependent Care Provider:	Date:
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Employee Certification: I request payment from my dependent care Flexible Spending Account for the expenses listed above. I certify these expenses have been incurred and qualify for reimbursement (refer to the Flexible Spending Accounts booklet or <http://www.umn.edu/ohr/benefits/fsa/>). I further certify that these expenses have not been and will not be reimbursed from another source.

Signature of Employee:	Date:
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Office Use Only

Approved by	Date	Verified by	Date	Claim No.
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