

**CAFETERIA PLAN  
DEPENDENT CARE CLAIM FORM**

Employer Name: \_\_\_\_\_

Participant's Name: \_\_\_\_\_  
Last First Middle

Social Security No.: \_\_\_\_\_

The undersigned participant in the Plan requests reimbursement (**attach itemized bills, receipts and invoices for all expenses claimed**) in the amounts shown below:

1. Name of Dependent(s) \_\_\_\_\_

2. Period Covered: From \_\_\_\_\_ through \_\_\_\_\_

3. Service Provider Information:

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

**Taxpayer ID # (Social Security Number):** \_\_\_\_\_

Amount \$ \_\_\_\_\_

**NOTE:**

The total amount claimed under the Plan for any coverage period must not exceed the lesser of your wages or salary for the Plan year or the wages or salary 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.

Adequately documented claims will be processed within three working days of receipt. Claims may be sent to:

Employee Benefit Resources, LLP  
P.O. Box 1193  
Helena, MT 59624  
(406) 449-5500 or (800) 765-9429

**Complete both sides of this form and sign where indicated.**

**READ CAREFULLY**

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form, were incurred during a period while the undersigned was covered under their employer's cafeteria plan with respect to such expenses. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for the payment of all related taxes including Federal, State or City income tax on amounts paid from the Plan which relate to such expense. The undersigned further understands that no dependent care tax credit is permitted for amounts for which reimbursement is made.

\_\_\_\_\_ Date \_\_\_\_\_  
Employee's Signature

**CAFETERIA PLAN  
CHILD CARE PROVIDER STATEMENT**

I have received \$\_\_\_\_\_ (amount received) from \_\_\_\_\_  
(participant) for the care of \_\_\_\_\_ (dependents) during the period  
from \_\_\_\_\_ to \_\_\_\_\_ (dates).

\_\_\_\_\_ Date \_\_\_\_\_  
Child Care Provider Signature