DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT PLAN
Claim Form

Company: _____ Employee Name: _____

This claim form is to be used only to request reimbursement from your Dependent Care Flexible Spending Account for dependent care expenses. In all cases, the actual bill that you received or receipt of payment or other evidence that you have incurred the expense must be submitted, with this claim form, when requesting reimbursement.

IN ALL CASES, YOU MUST SIGN THE BOTTOM OF THIS FORM

Date Expense Incurred	Name of Preschool or Day-Care Provider	Relation to Person for Whom Expense Incurred (i.e. son, daughter, parent)	Amount
		Total	

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 are valid.		
Dependent Care Provider Signature	Dependent Care Provider ID	Dates of Service

*I understand that I have the responsibility for any tax or other legal reporting requirements with respect to reimbursed expenses. I also understand that, to the extent dependent care expenses are reimbursed under this Plan, they may **not** be claimed as expenses for purposes of the credit against federal income tax for dependent care expenses.*

_____ _____

Employee Signature Date

When done, attach all necessary receipts and **mail, e-mail or efax** to:

Northeast Benefits Management, LLC
P.O. Box 2363, South Burlington, VT 05407-2363
Scan and email: info@nbmus.com
Fax: (802) 304-1009 (Burlington exchange)
Fax: (802) 304-1067 (Burlington exchange)

NBM
Employee Benefits Simplified