JFP Benefit Management, Inc.

Flexible Spending Account

DEPENDENT CARE REQUEST FOR REIMBURSEMENT FORM

Employee Name		ID#
Street Address		
City	State	Zip

Name of Child Care Provider	
Address	
Taxpayer Id # or S.S. #	
Name of Child/Children	

Period Covered: From _____ 20__

Through_____ 20__

Amount $_____

☐ I would like this amount to be automatically paid on a recurring expense until further notice.

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.

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 the EMPLOYERS **FLEXIBLE BENEFIT 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.

The undersigned further certifies that the dependent care has been provided by the provider listed above.

Attach provider statement showing amount requested. Employee Signature	 Date

Mail to: JFP Benefit Management, Inc. - P.O. Box 189 - Jackson, Michigan 49204
(800) 589-7660 or (517) 784-0535; or **Fax to**: (517) 784-0821 or **Email to:** cservice@jfpbenefitmanagement.com