SCHOOL DISTRICT OF THE CITY OF ADRIAN

DEPENDENT CARE ASSISTANCE PLAN

REQUEST FOR REIMBURSEMENT FORM

Participant's name: ______________________________ Soc. Sec. #: ________________________

Date of Service	Name of Dependent(s) for whom expense incurred	Description of Service	Amount of Expense
________	__________________________	_________________________________	____________
________	__________________________	_________________________________	____________
________	__________________________	_________________________________	____________
________	__________________________	_________________________________	____________
________	__________________________	_________________________________	____________

Total amount requested: $_________

I represent that the information provided above and attached hereto is true and accurate, and that I incurred the expenses listed above on behalf of a Dependent of mine. No part of this expense is reimbursable to me or my spouse or Dependent under any insurance contract or under any other plan of this or any other employer of myself, my spouse or my Dependent. I agree to provide such additional information as the Plan Administrator may require.

Participant's signature: ____________________________ Date: ________________________

Date received by Plan Administrator: ________________ Initials: _____________________

ATTACH COPY OF ORIGINAL INVOICES/RECEIPTS.

(You must also read and sign the reverse side of this form.)

EMPLOYEE STATEMENT

I understand that in order to be entitled to a reimbursement for "Eligible Employment Related Expenses" under the **Dependent Care Assistance Plan**, I must deliver to the Plan Administrator proof of the incurrence of the "Eligible Employment Related Expense" for a qualifying dependent during the Plan Year, and provide the following information on the reverse side of this form:

1. The qualifying dependent(s) for whom the dependent care services were rendered;
2. A description of the dependent care services;
3. The relationship to you, if any, of the person rendering the dependent care services;
4. If the services were rendered by a dependent of yours, the age of the dependent;
5. A description of where the dependent care services were rendered;
6. If the services were rendered outside of your home, a statement that the dependent for whom the services were rendered spends at least eight hours per day in your home;
7. If the services were rendered at a day care center, a statement that (a) the day care center complies with all applicable laws of the State of Michigan and the town, city or village in which it is located; (b) the day care center provides care for more than six individuals (other than individuals who reside at the center); and (c) the amount of the fee paid to the center; and
8. If you are married and your spouse is unemployed, a statement that your spouse is either incapacitated or a full-time student attending an educational institution, and the name of the institution, and the months during the year in which he/she will attend such institution.

THE INFORMATION REQUIRED IN ITEMS 1-8 ABOVE MUST BE PROVIDED ON THE REVERSE SIDE OF THIS FORM.

I have read, and I understand, the foregoing requirements regarding the rules applicable to the expenses relating to dependent care assistance, and the substantiation required by the Internal Revenue Service in order to be eligible for reimbursement. I certify that the requirements written above have been satisfied with respect to the expense described on the reverse side of this form for which I am seeking reimbursement. I agree to indemnify my Employer from any tax liability or costs attributable to any false or untrue statements made by me in seeking reimbursement for the attached expense.

____________________________ ____________________________

Employee's Signature Date

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