

FLEXIBLE BENEFITS PLAN

Dependent Care Expense Claim Form

Participant's

Name: _____
Last First Middle

Social Security No.: _____ Daytime Telephone No. _____
(optional)

E-Mail Address: _____

Fax to: (845) 677-2507 or Mail to: Malleolo Associates, Inc.
2510 Route 44 Suite 11
Salt Point, NY 12578
Attn: Flexible Benefits

Tel: (845) 677-2363

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

Name of Dependent(s): 1. _____ Age: _____
2. _____ Age: _____

Period Covered: From _____ To _____
From _____ To _____

Name of Provider: _____

Address: _____

Taxpayer Identification No. of Provider: _____
(or Social Security No. if applicable)

Signature of Provider: _____

Amount \$: _____

READ CAREFULLY

To the best of my knowledge and belief, my statements in this Form are complete and true. I certify all of the following: My family member has received the services described above on the dates indicated, and the expenses are my out-of-pocket expenses that qualify as valid Dependent Care Expenses under the Plan. The expenses listed are for my Dependent as defined in the Plan. I have not been reimbursed previously for these expenses under the DCAP. These expenses have not been reimbursed and I will not seek reimbursement for them under insurance or any other plan. I understand that the expenses reimbursed may not be used to claim any federal income tax deduction or credit (such as the Dependent Care Credit). I agree to file IRS Form 2441 with my tax return and provide any taxpayer identification number required thereon. The amount of reimbursement requested in this Form, added to the reimbursements to date (from any plan) do not exceed the statutory limits described in the Summary Plan Description.

Employee's Signature Date: _____

For Plan Administrator Use Only

Payment Authorized: _____ Amount: _____