FLEXIBLE BENEFITS PROGRAM
DEPENDENT CARE CLAIM FORM

Employer Name (District): _____
Participant's Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____

The undersigned participant in the plan requests reimbursement (attach itemized bills, receipts and invoices for all expenses claimed) in the amounts shown below. **Federal form W-10 for each child care provider must be on file in our office.**

1. Name of Dependent(s) _____

2. Period Covered: From _____ through _____

3. Name of person providing service: _____

*Amount $ _____

***NOTE:** The total amount claimed under the Plan for any coverage period must not exceed the lesser of your earned income for the plan year or the earned income 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 participant was covered under the Plan with respect to such expenses. The participant 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 participant, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the participant may be liable for payment of all related taxes on amounts paid from the Plan which relate to such expense.

_____ _____
Signature Date

Send completed claim forms to:

Flexible Benefits Program
Genesee Valley BOCES
80 Munson Street
LeRoy, NY 14482

For Plan Administrator Use Only:

Payment Authorized_____
Check No._____
Amount_____
Date _____