



2007 - 2008

DEPENDENT CARE REIMBURSEMENT CLAIM FORM

EMPLOYEE NAME _____
(Please Print)

I hereby request that St. Olaf College pay me the amounts listed below from my 2007-2008 dependent care reimbursement account under the St. Olaf College Flexible Benefits Plan.

An Independent Third Party Statement from the dependent care provider must accompany claims for reimbursement of dependent care expenses. This statement is an invoice/receipt that indicates the name of the provider, the name (s) of the dependent (s) for whom they are providing care, the dates of the service, and the total expenses incurred for the service. If your provider does not provide you with an invoice/receipt, a generic receipt form can be obtained from Human Resources for your provider to complete. **Cancelled checks or credit card receipts are NOT acceptable.** You will also need to complete the Itemized Section below for each submitted expense.

Dates of Service	Provider's Name	Name of Eligible Dependent (s)	Age of Dependent (s)	Total Expenses
Grand Total:				

I certify that: (1) These expenses were in fact incurred by me or my spouse for qualifying dependent care expenses under the terms of the St. Olaf Flexible Benefits Plan; (2) I have not been previously reimbursed for these expenses, and these expenses are not eligible for reimbursement or payment from any other source; (3) I understand that the expenses I am reimbursed may not be used to claim any federal income tax deduction or credit (including the dependent care tax credit) by me, my spouse or any other person.

DATE: ___/___/___

Employee Signature

Forms are due in the Human Resources Office by the 10th of the month. Forms submitted without an invoice/receipt will be returned to you for completion. Reimbursements will be electronically deposited along with your payroll directly into your account.

Date Received:

Approved By: _____