FLEXIBLE SPENDING ACCOUNT
REIMBURSEMENT FORM
DEPENDENT CARE ACCOUNT

PERSONAL INFORMATION:

Employer: ______________________ Plan Year: __________ SS #: ______________.

Employee Name: ______________________________________ Phone No: ____________.

Home Address: ____.

AUTHORIZATION:

I certify that the expenses for reimbursement requested from my Dependent Care Reimbursement Account (DCRA) is only for eligible dependents and were not reimbursed under any other benefit plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my DCRA. I (or we) understand that expenses reimbursed through the DCRA can not be used as deductions or credits when filing my (our) income tax return**.**

EMPLOYEE SIGNATURE: ______________________________ **DATE:** ______________**.**

DEPENDENT CARE INFORMATION

	Name of Dependent	Service Provider	SS# or FED ID#	Dates of Service	Reimbursement Requested
1.					
2.					
3.					
4.					
5.					
6.					
7.					

TOTAL______________________

Please review this form carefully. Forms improperly completed will be returned and may result in a delay in your reimbursement. Please submit a copy of the bill(s) and an explanation of benefits from your insurance company. **Canceled checks will not be accepted**.

Mail completed signed forms to:

Oneida BOCES
Flex Benefit Program
P.O. Box 70 Middle Settlement Road
New Hartford, NY 13413