2011-12 Hope College

Dependent Care Flexible Spending Account Request for Reimbursement

EMPLOYEE INFORMATION:

Name _____ Employee ID # _____

In order to reimburse expense, information must be provided in table below and receipts must be attached that include all the required information listed below:

1. provider's name & address & identification # (TIN or SSN)
2. date(s) of care/service
3. name of child(ren) for which care was provided

Dates of Care/Service*	Name of Child Care Provider	Child/Dependent's Name	Is your child/dependent 13 years or younger? (Yes/No)	Amount of Expense
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -

*date of care service must be within benefit year July 1 2011 - June 30 2012 to be considered eligible

Employee Authorization: I request payment from my FSA account for the incurred expenses outlined above. I certify that I have not received prior reimbursement under this plan or any other source. I have met all requirements for eligible expenses and that these reimbursed expenses cannot be claimed on my or my spouse's income tax returns.

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Employee Signature: _____ **Date :** _____

Send claims to Hope College's Human Resources Office, 100 East 8th Street, Suite 210, Holland, MI 49423. Please make copies, if needed, as documents will not be returned. Reimbursement requests must be received in HR one week prior to paydate to be included in your check. For claim questions, please visit website listed below or contact the HR Department @ 616.395.7811.

http://www.hope.edu/admin/hr/benefits/flex.html