MOC-FLOYD VALLEY COMMUNITY SCHOOLS
Dependent Care
Reimbursement Claim Form

Employee Name: ____ SS# _____-____- ______

Dependent Name(s): ____

____

____

Day Care Provider: ____ SS#_____-____-______

Address:____

____

Dates of Services: ____ Through _____________________

Charges for Services: ________________________ Per Hr. _______Per Day_______ Per Week ______

Total Charges: _______________________________

____

(Day Care Provider Signature)

Employee Certification

I hereby certify that all items requested to be reimbursed comply with the MOC-FLOYD VALLEY COMMUNITY SCHOOLS Flexible Spending Account and such items have not and will not be covered by any other plan or program of any employer or other person. I further certify that such items will not be deducted or taken as tax credits on my personal federal and state income tax returns for any year. The Company does not accept responsibility for direct payment to any individuals other than the employee.

Employee Signature ____Date ___________________

Three Rivers Benefit Corporation
PO BOX 3440 Sioux City, IA 51102
(712) 258-1525 PH
(712) 255-3521 FAX

NOTICE:

All employees participating in a Section 129 Dependent Care Flexible Benefit Plan are required to file Form 2441 with the IRS by April 15 of the year following your participation in this plan.