Southeast Dubois County School Corporation

FLEXIBLE BENEFIT PLAN
Claim Form For Dependent Care

MAIL TO PLAN SUPERVISOR:
Dunn Benefit Administrators
P.O. Box 2369
Columbus, IN 47202

(812) 378-9960
(800) 880-9960

Part 1. Please type or print clearly

Employee Name: _____

Address: _____

_____

Telephone #: _____

Social Security Number: _____

Group/Employee Number: _____

Employment Date: _____

Part 2. I certify that the expenses for which reimbursement is requested under my Flexible Benefit Plan were incurred by myself for my eligible dependents. I will not use expenses reimbursed through the Flexible Benefit Plan as deductions when filing my individual income tax return. I certify that these expenses are not reimbursable under any other plan, including a plan of another employer that covers me, my spouse or another member of my family.

_____ _____
Employee Signature Date

Part 3. PROVIDER ID INFORMATION

NAME OF CARE PROVIDER: _____

PROVIDER ADDRESS: _____

_____

PROVIDER'S SOCIAL SECURITY/ID NUMBER: _____

Part 4. List any dependents for whom you make dependent care payments:

DEPENDENT NAME	AGE	RELATIONSHIP TO EMPLOYEE
_____	_____	_____
_____	_____	_____
_____	_____	_____

DEPENDENT CARE BENEFIT

FOR PERIOD FROM _____ to _____ AMOUNT PAID $_____

FOR PERIOD FROM _____ to _____ AMOUNT PAID $_____

FOR PERIOD FROM _____ to _____ AMOUNT PAID $_____

FOR PERIOD FROM _____ to _____ AMOUNT PAID $_____