



THE EMPLOYEE BENEFIT
SERVICE CENTER

DEPENDENT CARE REIMBURSEMENT CLAIM FORM

LAST NAME	FIRST NAME	M. I.	SOCIAL SECURITY NO.
ADDRESS	CITY	STATE	ZIP

Dependent Care Expense Claim

Name of Dependent (s)	Period Covered To / From	Name, Address and Taxpayer ID Number of Service Provider	Amount Incurred
Total Dependent Care Expense Claim			

INSTRUCTIONS:

Complete this form in its entirety and attach all required receipts.
Your claim form must have the following in order to be processed:

1. Signature and date.
2. Date expense was incurred.
3. Copy of bill, explanation of benefit, invoice or other written statement from a third party which supports each reimbursement or request.

Read Carefully...

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the Company's Flexible Benefits Plan with respect to such expenses. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including, federal, state or city income tax on amounts paid from the Plan which relate to such expense.

Associate Signature

Date

Send this form and attachments to: *(Please keep a copy of all forms/attachments for your records)

The Employee Benefit Service Center
P.O. Box 8130
South Charleston, WV 25303