Remit To:
Plus Point Services
307 oak street
hood river, or 97031
PHONE: 541.386.1696
FAX: 541.386.2280
EMAIL: Admin@pluspoint-tpa.com

S125 Dependent Care Reimbursement

Daycare Claim Form

Employee Information			
Employer Name:		Daytime Phone:	
Employee Name:		Employee ID:	
Employee Address:			

City:		State:		Zip:	
Email Address:					

PLEASE NOTE: Claims that are not listed on this from cannot be processed. You must complete each field below for each claim you are seeking reimbursement for and attach supporting documentation.

Dependent Daycare Expense (Attach supporting documentation if provider does not sign form)

Supporting documentation for dependent care expenses is required only if provider does not sign this form. Otherwise, documentation must include the following:

--- Provider's Name
--- Tax ID
--- Dependent's Name
---- Address
---- Amount Billed

Date of Service		Name of Dependent	Name and Address of Dep Care Provider	EIN or SSN# of Provider	Amount
From	To				
				Total Amount Requested:	

DEPENDENT CARE PROVIDER'S VERIFICATION: I certify that the above charges are accurate as described

Provider Name: ______________________ Tax ID or SSN: ______________________

Address: ____

Provider's Signature: ______________________ Date: ______________________

Please Note: The daycare provider must declare this as income on their tax return.

Employee Confirmation

By signing this form I certify that the expenses for reimbursement listed above were incurred during the time specified for the care of a qualified dependent(s) under age of 13 or for a qualified dependent(s) who is incapable of self-care. I certify that these expenses have not previously been reimbursed by this or any other benefit plan, will not be reimbursed from any other source and will not be claimed as an income tax deduction when filing an income tax return.

Employee Signature: ______________________________________ Date: ______________