

REQUEST FOR REIMBURSEMENT DEPENDENT CARE REIMBURSEMENT PLAN



SELF-FUNDED PLANS, INC.
 1432 Hamilton Avenue
 Cleveland, Ohio 44114-1146
 (216) 566-1455 or
 1-800-722-7374

HOW TO FILE A CLAIM

TO ENSURE PROMPT PROCESSING OF YOUR CLAIM, PLEASE PROVIDE THE FOLLOWING INFORMATION. EXCLUSION OF REQUESTED INFORMATION MAY DELAY PROCESSING.

1. Complete the EMPLOYEE INFORMATION and EMPLOYEE CERTIFICATION sections of this form.
2. Complete the Reimbursable Expenses Section of this form in full.
3. Be sure to ATTACH A STATEMENT from the provider.
4. If this form is not completed in full, we will be unable to process your claim. This will delay reimbursement of funds you have already paid out.
5. Please send the completed forms to:
SELF-FUNDED PLANS, INC.
 1432 HAMILTON AVENUE
 CLEVELAND, OHIO 44114
 (216) 566-1455 or 1-(800) 722-7374

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY MISREPRESENTATION OR ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW AND MAY BE SUBJECT TO CIVIL PENALTIES.

EMPLOYEE INFORMATION

EMPLOYER NAME			ACCOUNT NUMBER
EMPLOYEE NAME	SOCIAL SECURITY NO.	HOME PHONE NO.	IS YOUR SPOUSE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO
MAILING ADDRESS			
STREET	CITY	STATE	ZIP CODE

EMPLOYEE CERTIFICATION

By signing below I certify that: (1) The charges listed on this form are eligible dependent care expenses under the Internal Revenue Code; (2) I have incurred these charges; (3) I have not been reimbursed by any entity for these charges; (4) I will not claim these expenses as deductions on my personal income tax return.

Employee Signature

Date

FOR EACH EXPENSE SUBMITTED, MAKE SURE YOU HAVE ATTACHED A STATEMENT FROM THE PROVIDER OF SERVICE WHICH SHOWS THE TYPE OF EXPENSE INCURRED, THE DOLLAR AMOUNT, AND THE DATE IT WAS INCURRED.

REIMBURSABLE EXPENSES

For each dependent care expense for which you are requesting reimbursement, please complete the following:

Name of Provider of Service with Tax ID #	Date(s) of Service	Total Charge	Name and age of Dependent	Amount to be Reimbursed
Total Requested				

SIGNATURE OF SERVICE PROVIDER