



UNION COLLEGE HEALTH/DEPENDENT CARE REIMBURSEMENT ACCOUNT CLAIM FORM

RETURN ORIGINAL FORM TO PAYROLL IN McKEAN HOUSE
Yellow copy is for your Records

PART A: CLAIMANT DATA

Name of Covered Employee: _____

Employee Union College Identification Number: _____

Individual(s) for whom Documentation of Expense is attached:

Individual(s) Name	Birthdate	Circle One
1. _____	_____	Self Spouse Dependent Child
2. _____	_____	Self Spouse Dependent Child
3. _____	_____	Self Spouse Dependent Child

PART B: EXPENSES TO BE REIMBURSED

Name of Individual and Description of Expense	Date Incurred	Amount Eligible for Payment Under This Plan*
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

If claiming Dependent Care expenses, please provide Address and Social Security number or TAX I.D. number of care provider.

***IMPORTANT: PLEASE READ THE FOLLOWING**

ATTACH *ORIGINAL RECEIPTS* SUPPORTING EACH LISTED ITEM OF EXPENSE

Do not include amounts paid or eligible for payment under any other health care plan or program, federal, state or governmental program, worker's compensation, or any other health insurance.

PART C: EMPLOYEES STATEMENT

I hereby certify that the information contained in Part B of the Claim for Reimbursement is to the best of my knowledge and belief true and correct, and each item of expense is eligible for reimbursement. I understand that I am responsible for providing proof to support a reimbursed expense and any reimbursed expense later discovered to be not eligible for reimbursement will be taxable to me. In addition, I understand that Dependent Care expenses paid with pre-tax dollars cannot be claimed on my income tax return.

Date

Signature of Employee

INSTRUCTIONS FOR REIMBURSEMENT

Complete all three sections (A,B,C) on the front of this form and attach supporting documentation.

The following supporting documentation is required:

EXPENSES COVERED BY YOUR HEALTH CARE PLAN: Medical expenses covered by your health care plans or those of your spouse must be submitted under those plans first. Attach **ORIGINAL** of the explanation of benefits statement in order to claim amounts not paid by other health care plans.

OTHER HEALTH CARE EXPENSES: For all other eligible health care expenses, attach **ORIGINAL** bills that clearly state:

Name of person receiving the service
Nature of the service or supplies furnished
Name and address of the provider of the services
Amount charged
Date the service was rendered

DEPENDENT CARE EXPENSES: Attach **ORIGINAL** bill, receipt of payment, or canceled check. The supporting documentation should show.

Name of the dependent receiving the service
Nature of the service
Name and address of the provider of services
Tax ID number or Social Security number
Amount charged
Date (or date range) the service was rendered