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**DEPENDENT CARE ASSISTANCE EXPENSES
 REIMBURSEMENT REQUEST FORM**

Employer Name THSD 214		Employee Type	Group No. A06157
Employee's Last Name	First	M.I.	Birth Date (Mo./Day/Yr.)
Street Address	City	State	Zip Code
Social Security No.	Telephone No.:	Sex: Male Female	
Dependent Care Expenses			
Dependent Name(s)	Relationship		Age
1.			
2.			
3.			
Dependent Care Provider Name			
Street Address			
City	State	Zip	
Tax I.D. or Social Security No.			
Dates of Care	Amounts		
			\$
			\$
TOTAL AMOUNT REQUESTED			\$
Provider's Signature (or attach receipt): _____			
Date: _____			
Is Provider of Service related to dependent? Yes No. If yes, please list age and relationship of provider:			
Age:	Relationship:		
I certify that the expenses listed above qualify for reimbursement and have been incurred and paid by me or by eligible members of my family. In claiming reimbursement for dependent care expenses, I certify that my spouse and I WILL NOT receive reimbursement in excess of \$5,000 from all employer sponsored dependent care accounts.			
Participant's Signature: _____ Date: _____			