

VOUCHER FOR DEPENDENT CARE EXPENSE

(This includes a licensed daycare, a private sitter, or even a relative that you pay to watch your child (ren) while you work. This will also cover a dependent spouse or dependent parents that live with you that need care while you work.)

Claim for Reimbursement

Fax No: 270-769-2521 or 1-866-812-9671

Mail to Address: Employee Benefits Administrators
P.O. Box 2525
Elizabethtown, KY 42702

NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SOCIAL SECURITY _____ EMPLOYER _____

Dependent Care Expense Claims

Name of Dependents	1.Beginning Date 2.Ending Date	1. Service Provider Name and Address 2. Taxpayer Identification Number	Claim Amount
_____	1. _____ 2. _____	1. _____ 2. _____	_____
_____	1. _____ 2. _____	1. _____ 2. _____	_____
_____	1. _____ 2. _____	1. _____ 2. _____	_____
_____	1. _____ 2. _____	1. _____ 2. _____	_____
_____	1. _____ 2. _____	1. _____ 2. _____	_____

TOTAL DEPENDENT CARE EXPENSE CLAIM \$ _____

Read Carefully

The above is a true and accurate statement of dependent care expenses incurred by me or my eligible dependents on the date(s) indicated, and was incurred while I was covered under the ProPlus 125 Cafeteria Plan. Receipts from my service provider(s) for all expenses are attached to this voucher. I understand I cannot claim any reimbursed expenses on my income tax return, and that I may be liable for payment of all related taxes including Federal, State, or City income tax on the amounts paid for any expense improperly claimed under the plan.

Signature _____ **Date** _____ / _____ / _____