



Plan Year January 1,2008– December 31,2008

Dependant Care Spending Account  
Reimbursement Claim Form

**\*\* Please submit all appropriate receipts with this claim form and retain a copy for your records\*\*.**

Part I

Employee Name: \_\_\_\_\_

SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Dependant Name(s): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Part II

Day Care Provider: \_\_\_\_\_

SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

And Or Federal Tax I.D #:

Address: \_\_\_\_\_

\_\_\_\_\_ - \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Charges for Services: \_\_\_\_\_ Per Hr: \_\_\_\_\_ Per Day: \_\_\_\_\_ Per Wk: \_\_\_\_\_ Per Mth: \_\_\_\_\_

Total Charges: \_\_\_\_\_

\_\_\_\_\_  
Day care Provider Signature/Date

**Employee Certification**

I hereby certify that all items requested to be reimbursed comply with Hoffman Car Wash Inc. flexible spending account and such items have not and will not be covered by any other plan or program of any employer or person. I further certify that such items will not be deducted or taken as tax credits on my personal federal and state income tax returns for any year. The company does not accept responsibility for direct payment to any individuals other than the employee.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date