Return to:
Madison-Oneida BOCES
4937 Spring Road, P.O. Box 168
Verona, NY 13478-0168
Attn: Flex Plan Office

FLEXIBLE SPENDING PLAN
DEPENDENT CARE ACCOUNT
REIMBURSEMENT REQUEST FORM

PERSONAL INFORMATION

Employer	For Plan Year	Social Security Number
Madison-Oneida BOCES	_____	XXX-XX-

Employee name (Last) (First) (Initial)	Telephone Number	Date of Birth

Home Address Street City State Zip

PERSONAL INFORMATION

NAME OF DEPENDENT RECEIVING SERVICE	RELATIONSHIP TO EMPLOYEE	PROVIDER OF SERVICE	SOCIAL SEC. # OR FED. ID #	DATES OF SERVICE FROM	DATES OF SERVICE TO	AMOUNT TO BE REIMBURSED

AUTHORIZATION

I certify that, to the best of my knowledge, the above information is accurate and that reimbursement is being requested only for expenses of eligible dependents. I am requesting reimbursement only for eligible expenses as defined in the summary plan description that have not and will not be paid under any other benefit plan or claimed as a credit on my Federal income tax return.

Employee Signature _____ Date _____

Please submit a copy of the bill(s), receipts or care provider contract.
Please review this form carefully. Forms improperly completed will be returned and may result in a delay in your reimbursement.