CAFETERIA PLAN CHILD/DEPENDENT CARE REIMBURSEMENT REQUEST VOUCHER

Rev.9/2015

EMPLOYER: CANYON I.S.D.

PLAN YEAR: SEPTEMBER 1, 2015 – AUGUST 31, 2016

PLEASE REMEMBER TO SIGN VOUCHER DO NOT CUT VOUCHER

COMPLETE THIS SECTION FOR CHILD/DEPENDENT CARE REIMBURSEMENT

1. **PRINTED NAME OF PROVIDER: _____**
2. **ADDRESS OF PROVIDER: _____**
3. **CITY, STATE, ZIP: _____**
4. **DATE OF SERVICE (M/D/Y):_____ AMOUNT PAID :_____**
5. **NAME OF CHILD(REN): _____**
6. **SIGNATURE OF PROVIDER: _____**

***PLEASE NOTE* :**
A: YOU WILL BE REIMBURSED UP TO THE MAXIMUM DOLLAR AMOUNT REMAINING IN YOUR ACCOUNT.
B: WE CANNOT REIMBURSE YOU FOR DEPENDENT CARE EXPENSES ON CHILD CARE NOT YET COMPLETED.
C: RECEIPTS MUST INCLUDE CHILD/CHILDREN'S NAME, SERVICE DATES AND AMOUNT PAID.

TOTAL REQUESTED $ _____

I certify that I have incurred expenses in the amounts shown above that qualify for reimbursement under the provisions of my employer's Dependent Care Assistance Program (DCAP). I further certify that I have enclosed copies of the necessary records or receipts to substantiate the above amounts. **(*Please note that canceled checks, credit card statements or receipts will not be accepted.)*

Employee printed name: _____ SS#_____

Employee address: _____Hm Phone:_____
☐ **CHECK BOX IF THIS IS AN ADDRESS CHANGE**

City:_____ Zip:_____ Wk Phone:_____

Date: _____ Employee Signature: _____

PLEASE EMAIL COMPLETED FORMS AND RECEIPTS TO: cjobson@txbenefitservices.com
For questions, call TOLL FREE 1-800-594-4100

TEXAS BENEFIT SERVICES, L.L.P., P.O. BOX 1130, SPRING BRANCH, TEXAS 78070