Missoula County Risk & Benefits
200 West Broadway
Missoula, MT 59802
Phone (406) 523-4876
Fax (406) 523-4731
For additional forms, go to
http://www.missoulacounty.us/government/administration/risk-benefits

FLEX DEPENDENT CARE REIMBURSEMENT REQUEST

Use this form to submit claims by fax or mail. Please complete the applicable spaces on this form, attach appropriate documentation, and forward to Missoula County Risk & Benefits Department. Do NOT include medical, dental or vision expenses on this form.

Plan Year _____ Department _____ Daytime Phone# _____

Employee Name _____ Soc. Sec. No _____

Please Print. Last First

Street or Box Number City State Zip

DEPENDENT CARE EXPENSE CLAIMS

Dependent Name(s)	Period Covered		Name, Address and Tax ID Number of Provider of Service	Dependent Care Expenses Incurred
	From	To		
			Total Dependent Care Expenses (Minimum $10)	**$**

For Dependent Care Expenses, the following must be completed by the Dependent Care Provider:

To the best of my knowledge, I certify that the information above regarding dependent care expenses is complete and true. I certify services were necessary for my and/or my spouse's employment and that services were for tax dependent child(ren) under the age of 13 or any elderly/handicapped dependent. I further understand that expenses reimbursed by Flex may not be claimed on my income tax return as an income tax reduction. I authorize my Flexible Spending Account to be reduced by the amount requested.

Signature **Date**