

CAFETERIA PLAN DEPENDENT CHILD CARE REIMBURSEMENT REQUEST VOUCHER

Rev. 10/2011

EMPLOYER: CANYON I.S.D.

PLAN YEAR: SEPTEMBER 1, 2011 – AUGUST 31, 2012

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 receipts or statements only reflecting a previous balance will not be accepted.)

Employee printed name: _____ SS# _____

Employee address: _____ Hm Phone: _____

City: _____ Zip: _____ Wk Phone: _____

Date: _____ Employee Signature: _____

TEXAS BENEFIT SERVICES, L.L.P., P.O. BOX 1130, SPRING BRANCH, TEXAS 78070
FAX (830) 885-2693 TOLL FREE 1-800-594-4100