CHIPPEWA HILLS SCHOOL DISTRICT

DEPENDENT CARE ASSISTANCE PLAN

REQUEST FOR REIMBURSEMENT FORM

Participant's Name: _____

Date of Service	Name of Dependent(s) For Whom Expense Incurred	Description of Services	Amount of Expense

Total Amount Requested: $ _____

I represent that the information provided above and attached hereto is true and accurate, and that I incurred the expense listed above on behalf of a Dependent of mine. No part of this expense is reimbursable to my spouse or me or Dependent under any insurance contract or under any other plan of this or any other employer of my spouse, my Dependent or myself. I agree to provide such additional information as the Plan Administrator may require.

Participant's Signature: _____ Date: _____

Date received by Plan Administrator: _____ Initials: _____

ATTACH COPY OF ORIGINAL INVOICES/RECEIPTS.