COUNTY OF MENDOCINO
FLEXIBLE BENEFITS PLAN
DEPENDENT CARE REIMBURSEMENT PLAN CLAIM FORM

Social Security No.:________________________ Employee No.:____________________________

Participant's Name:____
Last Name First Name Middle Initial

The undersigned participant in the plan requests reimbursement (attach itemized bills, receipts, and invoices for all expenses claimed) in the amount shown below:

1. Name of Dependent (s) ____

2. Period Covered: From _________________________, 20___Through _____________________, 20___

3. Name, address, and tax payer identification number of person providing service and description of service:

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*Amount $ ___________________________

*NOTE: The total amount claimed under the Plan for any coverage period must not exceed the lesser of your earned income for the plan year or the earned income of your spouse. (If your spouse is either a full-time student or is incapable of taking care of himself or herself, then he or she is deemed to have monthly earnings of $200 if there is one (1) child or dependent, and $400 if there are two (2) or more). No payment may be made under the Plan if the service provider is your dependent for federal income tax purposes or is your child or stepchild and is under age 19.

READ CAREFULLY

The undersigned participant in the plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the County of Mendocino Flexible Benefits Plan with respect to such expenses. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

____ __________________________
Employee's Signature Date

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For Plan Administrator use only:
Payment Authorized _____________________________ Check No. ____

Amount $ ____ Date ____

SEND CLAIM TO: DELTA HEALTH SYSTEMS, P.O. BOX 1199, STOCKTON, CA 95201-1199
PHONE: (800) 291-0726 OR FAX (209) 474-5430