MECOSTA-OSCEOLA INTERMEDIATE SCHOOL DISTRICT
15760 190th Avenue, Big Rapids, MI 49307
(231) 796-3543 FAX (231) 796-3300

REQUEST FOR REIMBURSEMENT FORM

CAFETERIA/MEDICAL EXPENSE REIMBURSEMENT/DEPENDENT CARE ASSISTANCE PLANS

Employee's Name: _____

Social Security Number: _____

Type of Expense: _____ Medical Care **OR** _____Dependent Care

Date Expenses Incurred: _____

Amount of Expense: _____

Name of Individual for whom
Expense was incurred: _____

Relationship: _____

Describe Expense: _____

_____

_____

_____

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

Employee's Signature: _____ Date: _____

Date received by Plan Administrator: _____ Initials: _____

ATTACH COPY OF ORIGINAL RECEIPTS.

For dependent care expenses, you must read and sign the reverse side of this form.

EMPLOYEE STATEMENT

I understand that in order to be entitled to a reimbursement for "eligible employment related expenses" under the Mecosta-Osceola Intermediate School District Dependent Care Assistance Plan, I must deliver to the Plan Administrator proof of the incurrence of the "eligible employment related expense" for a qualifying dependent during the Plan Year, and provide the following information on the reverse side of this form:

1. The qualifying dependent(s) for whom the dependent care services are to be (or were) rendered;

2. A description of the dependent care services;

3. The relationship to you, if any, of the persons rendering the dependent care services;

4. If the services are to be (were) rendered by a dependent of yours; the age of the dependent;

5. A description of where the dependent care services will be rendered;

6. If the services are to be (were) rendered outside of your home, that the dependent for whom the services are (were) rendered spend at least eight (8) hours per day in your home;

7. If the services are to be (were) rendered at a day care center, (a) the day care center complies with all the applicable laws of the State of Michigan and the town, city or village in which it is located; (b) the day care center provides care for more than six (6) individuals (other than the individuals who reside at the center); and (c) the amount of the fee paid to the center; and

8. If you are married and your spouse is unemployed, your spouse is either incapacitated or a full-time student, and the name of the school and the months during the year in which he/she will attend.

THE INFORMATION REQUIRED IN ITEMS 1-8 ABOVE MUST BE PROVIDED ON THE REVERSE SIDE OF THIS FORM.

I have read, and I understand, the foregoing rules regarding the rules applicable to the expenses relating to dependent day care assistance, and the substantiation required by the Internal Revenue Service in order to be eligible for reimbursement. I certify that the requirements written above have been satisfied with respect to the expense described on the reverse side of this form for which I am seeking reimbursement. I agree to indemnify my employer from any tax liability or costs attributable to any false or untrue statements made by me in seeking reimbursement for the attached expense.

_____ _____

Employee's Signature Date