BALDWIN-WALLACE COLLEGE
MONTHLY CLAIM FORM FOR THE YEAR _____
DEPENDENT CARE REIMBURSEMENT ACCOUNT
(Please Fill Online or Print Legibly)

Employee Name: _____

Department: _____ **Ext:** _____

Home Address: _____

_____

Qualified dependents include a child who is under the age of thirteen, a spouse who is physically or mentally incapable of caring for himself or herself, and a relative or household member over half of whose support is received from you and who is physically or mentally incapable of caring for himself or herself.
Allowable expenses include amounts paid for care for qualified dependents to day care centers, nursery schools, and baby sitters or attendants who are not your own dependents, if the care is necessary to enable you (and your spouse, if applicable) to work. Submit invoices, receipts, or cancelled checks with this claim form. **Note: On the reverse side of this form, fill out expenses submitted. Be sure to include the provider's Social Security or Employer Identification Number. This is an IRS requirement. The college must file an annual return listing these payments**.

Certification: I certify that the dependent care expenses for which I am asking reimbursement in this claim are allowable expenses that have not been reimbursed by any other plan and are not eligible for reimbursement by any other plan.

_____ _____
Employee Signature Date

Send this form with attachments in a sealed envelope to **Lisa Giesen**, Finance Office, before the 20th of the month. We pay claims monthly on the 30th, in a single check payable to the employee. Claims received after the 20th will be paid the following month.

US Mail ☐ Campus Mail ☐ Hold Check ☐
Phone Number

Office Use Only

Approved ☐ Date _____ Account Balance _____ Date _____

Expenses Submitted

Social Security Number for individuals or Employer Identification Number for organizations

Provider's Name	Provider's Number *	Dependent's Name	Relationship to Employee	Dollar Amount
				$0.00

Reset Form Please