WHITE RIVER VALLEY SU SECTION 125 CAFETERIA PLAN

Dependent Day Care Expense Claim Form

Name (last, first, MI)	Social Security #
School District	**Date**

Name of Dependent(s):

Period of Care: through

Amount Requested (care provider complete Affidavit section below or attach receipts or invoices):

Service Provider Information

Name:

Address:

Provider's Tax ID# or Social Security #:

Description

Affidavit of Dependent Care Services Rendered

I have provided adult/child care for _____ for the period beginning _____

and ending _____. Services were provided to _____ for a fee of $_____

Signature of Care Giver _____ Tax ID# or SS# _____ Date _____

NOTE	The total amount claimed under the plan must not exceed the lesser of your wages or salary for the plan year, or the wages or salary of your spouse. (If your spouse is either a fulltime student or is incapable of taking care of himself or herself then he or she is deemed to have monthly earnings of $250 if there is one child or dependent, and $500 if there are two 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.
IMPORTANT	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 in which the undersigned was covered under the White River Valley Supervisory Union Section 125 Cafeteria 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 and state income taxes and social security taxes on amounts paid from the plan which relate to such expense. The undersigned further understands that no dependent care tax credit is permitted for amounts for which reimbursement is made.

Participant's Signature	**Date**

Please return completed form to: Future Planning Associates, Inc.
ATTN: White River Valley SU Plan Administrator
P.O. Box 905
Williston, Vermont 05495-0905
Phone: *(802) 857-0685;* ***scan and e-mail: belinda@futureplanningassoc.com***
FAX: 802/857-0705 – If faxing this request, to avoid duplication, **DO NOT** mail.

This form must reach Future Planning Associates by the 2nd or 4th Tuesday each month
•Disbursements are paid the following week •
End of Plan Year claims for expenses incurred on or before December 31st must be submitted by January 30th.

Plan Year: 2016/2017