WEST VIRGINIA WESLEYAN COLLEGE
CAFETERIA PLAN

DEPENDENT CARE EXPENSE CLAIM FORM

Employee No.: _____

Participant's Name: _____
Last First Middle

The undersigned participant in the Plan requests reimbursement in the amounts shown below. (Attach itemized bills, receipts and invoices for all expenses claimed.)

a. Name of Dependent(s): _____

b. Dates Covered: From _____20 _____

To _____20_____

c. Name, address and, except for certain tax exempt organizations, the taxpayer identification number of the service provider, and description of service:

_____

_____

_____

_____

Amount $_____

NOTE: The total amount claimed under the Plan for any coverage period 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 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 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 West Virginia Wesleyan College 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 the payment of all related taxes including federal, state or city income tax 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.

_____ te: _____
Employee's signature

For Plan Adminstrator use only	For Employer use only
Payment Authorized: _____	Check No.: _____
Amount Authorized: $ _____	Date: _____