

**SANTA ROSA COUNTY  
FLEXIBLE BENEFITS PLAN  
DEPENDENT CARE REIMBURSEMENT CLAIM FORM**

\_\_\_\_\_ **Please check if address change**

Social Security No: \_\_\_\_\_

Participant's Name: \_\_\_\_\_ Daytime Telephone Number: \_\_\_\_\_

Participant's Address: \_\_\_\_\_

Name of Dependent(s): \_\_\_\_\_

Period Covered: \_\_\_\_\_

Name and address of person or day care center providing service and description of services:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Provider I.D.#/Signature \_\_\_\_\_

The undersigned participant in the plan requests reimbursement in the amount shown below.

**Please attach receipts, bills or invoices.**

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 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 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 amount 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.

\_\_\_\_\_  
*Employee's Signature*

\_\_\_\_\_  
*Date*

**Send claims to:  
Lockard & Williams Insurance Services, P.A.  
P.O. Box 1028  
Gonzalez, FL 32560**

**SANTA ROSA COUNTY  
FLEXIBLE BENEFITS PLAN  
HEALTH CARE REIMBURSEMENT CLAIM FORM**

**Fax (850) 479-2923**

**Phone (800) 530-722**