

**THE UNIVERSITY OF TENNESSEE FLEXIBLE BENEFITS PLAN  
DEPENDENT CARE REIMBURSEMENT CLAIM FORM**

Employee Name (please print) \_\_\_\_\_

I.D No. or Personnel No. \_\_\_\_\_

Monthly  Biweekly

Office Telephone Number \_\_\_\_\_

Expenses for Calendar Year 20 \_\_\_\_\_

**Claim Information**

Dates of Incurred Expenses	Dependent Name	Relationship to Employee	Provider Of Service	Amount
Total of Reimbursement				\$

I hereby certify that all expenses indicated above were incurred by my eligible dependents. I further certify that I have not previously received reimbursement for these expenses from The University of Tennessee Flexible Benefits Plan. I understand that I am solely responsible for the validity of claims submitted for reimbursement and that any expenses reimbursed through the Flexible Benefits Plan cannot be claimed on my personal Federal income tax return.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Provider's Signature (if no invoice attached)

\_\_\_\_\_  
Provider's Address

\_\_\_\_\_  
Provider's Social Security Number/EIN

\_\_\_\_\_  
Provider's Address

**REQUIRED DOCUMENTATION FOR DEPENDENT CARE REIMBURSEMENT**

Each dependent care expense claimed on this form must be supported by an invoice or statement which includes:

- \*Provider of Service
- \*Provider Address
- \*Dependent Name
- \*Dates of Expense
- \*Amount of Expense
- \*Provider SSN/EIN

Return to:  
The University of Tennessee  
Payroll Office  
P115 Andy Holt Tower  
Knoxville, TN 37996-0100  
(865)974-5251 (865) 974-3530 fax

If you do not receive an invoice or statement from your provider, ask the provider to sign the claim form, enter their Social Security Number or Employer Identification Number and address.

**DUE DATES**

Monthly: Claims must be received in the UWA Payroll Office by the 15<sup>th</sup> of the month (10<sup>th</sup> for December).  
Biweekly: Claims must be received in the UWA Payroll Office on Monday the week before payday.