Date Received

MSMA USE ONLY

MSMA GROUP INSURANCE TRUST CHOICE PLAN
DEPENDENT CARE EXPENSE REIMBURSEMENT REQUEST

INSTRUCTIONS: Complete this form and attach a receipt, which includes a description of the expense, date(s) of service, amount paid, the provider's name, address and federal tax-payer identification number. Do not send copies of checks or charge-card receipts.

Employee Name: _____ Employer: _____

Please fill out this information only if a change has taken place since your enrollment or last claim submission

Home Phone: _____ Work Phone: _____

Mailing Address:_____

Please complete the following:

NAME RELATIONSHIP

_____

_____

DATE(S) DAYCARE EXPENSES WERE INCURRED AMOUNT PAID

_____

_____

TOTAL AMOUNT PAID $_____

I CERTIFY THAT: all items submitted for reimbursement comply with the Section 125 Reimbursement Plan and such items have not and will not be paid by any other plan of any employer or any other person. I also certify that such items will not be deducted or taken as tax credits on my personal federal or state income tax return any year.

EMPLOYEE SIGNATURE: _____ DATE: _____

Note: prepare to file the IRS form 2441 with your tax return.

Send your request for reimbursement to:

MSMA-GIT/129
49 Community Drive
Augusta, ME 04330

Please call with any questions:
In state: 1-800-660-8484
Out of state: (207) 622-3473

(FOR OFFICE USE ONLY)

APPROVED _____ DATE _____

DATE PAID _____CHECK #_____

CLAIM NUMBER_____

PY **1** PY **2**