SECTION 125 PLAN

DEPENDENT CARE CLAIM FORM

Employee Name: _____ SSN: (last 4 digits only)_____

The undersigned participant in the plan requests reimbursement (attach itemized bills, receipts and invoices for all expenses claimed) in amounts shown below:

1. Name of Dependent(s) _____

_____

_____

2. Period Covered From: _____ through _____

3. 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 plan year 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 $250 if there is one (1) dependent, and $500 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 City of Traverse City Section 125 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.

Employee's signature: _____ Date: _____

Please keep a copy for your records