

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

Employee Name \_\_\_\_\_

Monthly    Biweekly

    

Responsible Account \_\_\_\_\_

Social Security Number \_\_\_\_\_

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

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

**Claim Information**

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

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

\_\_\_\_\_  
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's Address
- Dependent Name
- Dates of Expense
- Amount of Expense

Return to:

The University of Tennessee  
Payroll Office  
P115 Andy Holt Tower  
Knoxville, TN 37996-0100  
Telephone  
(423) 974-5251

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 and address.