

# Reimbursement Request for Dependent Care Expenses

*FlexChoice: A flexible benefits plan*

Mail this request (and any supporting documentation) to MMA FlexChoice or fax to (574) 537-6642.

Group name \_\_\_\_\_

Employee name \_\_\_\_\_ Social Security number \_\_\_\_\_

If recent change in address, please update.

Address \_\_\_\_\_  
street city state ZIP

## Dependent care expenses

Dates of Service	Name of Dependent Receiving Care	Name of Provider	Requested Amount
<b>Total</b>			

I understand and agree that the total amount of dependent care reimbursement for the plan year **cannot exceed the lesser of my earned income, or the earned income** of my spouse. I understand that dependent care expenses cannot be claimed as tax credit on my personal income tax return or reimbursed by any other source.

I fully understand and agree that, by signing this form, I assume responsibility for any liability which arises out of submission or payment of a request for reimbursement. I will solely be liable for any penalties or damages as a result of an inappropriate claim being filed.



**MMA**<sup>®</sup>

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Goshen IN 46527

Toll-free: (800) 348-7468  
Telephone: (574) 533-9511  
www.mma-online.org

\_\_\_\_\_  
Employee's signature

\_\_\_\_\_  
Date

**Please attach a signed receipt from your provider or complete the receipt below.**

## Receipt for dependent care

I, \_\_\_\_\_, have provided dependent care for \_\_\_\_\_  
name of provider name of dependent

on the following dates \_\_\_\_\_ and have received \_\_\_\_\_ in payment.  
amount

\_\_\_\_\_  
Signature of dependent care provider

\_\_\_\_\_  
Date