



Flexible Benefits Plan



Dependent Care Reimbursement Voucher Form

EMPLOYER NAME: RESEARCH FOUNDATION FOR MENTAL HYGIENE, INC.

GROUP: 1885

EMPLOYEE NAME: _____ SOCIAL SECURITY NO. -

EMPLOYEE ADDRESS: _____ () _____
Number/Street City State Zip Daytime Phone Number

Email: _____ Yes, I want to receive my Quarterly Statements and other communications by email

Please check if this is a new address.

For CFH use only

Instructions:

- Each expense **must** be itemized on this form and substantiated by a written statement from the provider of the qualifying service certifying:
 - The date, or range of dates, the service was provided
 - A description of the service provided
 - The amount charged
 - The name of the provider
 - The name of the person to whom it was provided
- Canceled checks will not be accepted for claim substantiation.** Attach bills or receipts.
- Please be sure to sign and date this form.
- Please make a photocopy of the reimbursement voucher form and documentation for your records. Your completed Reimbursement Voucher Form and supporting documents must be submitted to the following address, to ensure prompt reimbursement:

Important:

Your claim will be returned unless all of the listed elements are clearly identified on your receipt.

Flex Claims

Charles F. Herman & Associates, Inc.

PO Box 13565

Albany, NY 12212-3565

Ofc 518-370-8696 Fax 518-370-8699

Dependent Care Expenses			
Date of Service	For the Benefit of: (Name and Relationship)	Description of Service	Amount
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
Dependent Care Total			\$

CERTIFICATION

The expenses listed on this form are eligible under the Flexible Benefits Plan. I certify that I have incurred these expenses on behalf of my eligible dependent(s). I will not seek reimbursement from any other source and I will not claim these expenses as a deduction or for a credit when filing Internal Revenue Service Form 1040.

Employee Signature: **X** _____

Date: _____