

HARDING UNIVERSITY
Flexible Spending Account
Dependent Care Reimbursement Claim Form

Employee Name: _____ Banner ID# _____

Dependent Name(s): _____

Day Care Provider: _____

Address: _____

Dates of Service: _____ Through _____

Charge for Service: _____ Per Hour _____ Per Day _____ Per Week _____

Total Charges: _____

Employee Certification

I hereby certify that all items requested to be reimbursed comply with the Harding University Dependent Care Reimbursement Account and such items have not been and will not be reimbursed by any other plan or program of any employer or other person. I further certify that such items will not be deducted or taken as tax credits on my personal federal and state income tax returns for any year. Harding University does not accept responsibility for direct payment to any individuals other than the employee.

Employee Signature

Date

Submit claims to **Human Resources, Box 12257.**