

# Request For Reimbursement of Day Care Expenses



**FAX** this form and receipt to: 502-695-9692

FEBCO  
P.O. Box 5010  
Frankfort, KY 40602  
Fax: 502-695-9692



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

Social Security Number: \_\_\_\_\_ Employee Phone Number \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email address: \_\_\_\_\_ @ \_\_\_\_\_

If this is a new address, please indicate by checking the box.

## Dependent Information:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship: \_\_\_\_\_

Period Covered From: \_\_\_\_\_ To: \_\_\_\_\_ Amount: \$ \_\_\_\_\_

## Attach A Receipt Or Complete The Following:

Received \$ \_\_\_\_\_ on \_\_\_\_\_ from \_\_\_\_\_  
(amount) (date) (payor)

for the care of children indicated above, for the period of time indicated above.

\_\_\_\_\_  
Original signature of Day Care Provider

Dependent care receipts must include the name and address of your daycare provider, the names of any dependents receiving care, the coverage period for which the care was provided, as well as an itemized list of charges.

Please reimburse the above request to me based on the information I have provided from my dependent care provider and in accordance to current guidelines. I certify these expenses to be true to the best of my knowledge.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date