



TML Intergovernmental Employee Benefits Pool
 PO Box 140167
 Austin, Texas 78714-0167
 Fax: (512) 719-6505



DEPENDENT CARE REIMBURSEMENT FORM

Employer Name San Marcos			Employer Group # ASANMAR1	
Employee Name			Unique Identification Number	
Street Address	City	State	Zip Code	<input type="checkbox"/> Check here if new

Name of Individual or Organization providing Dependent Care Services	Tax ID or SS#	Date Incurred	Amt to be Reimbursed	Expense for care of: (Name)
_____	_____	_____	\$ _____	_____
Name				
_____	_____	_____	\$ _____	_____
Address				
_____	_____	_____	\$ _____	_____
Name				
Total			\$ _____	

 Employee Signature Date

AUTHORIZATION: I certify the above information to be correct and true to the best of my knowledge and that any children listed are dependents under Section 152 of the Internal Revenue Code. I understand that any amounts remaining in my account(s) not used for expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws. I also understand that the Flexible Spending reduction(s) will be in effect for the plan year and cannot be revoked unless I experience a change in my family status, significant change in cost or coverage of my health plan or my spouse's health plan or separation from service as prescribed by IRS rules. If a change in family status occurs, you have 31 days from the occurrence to change or revoke your election. Furthermore, I hereby authorize my employer to transfer my required health benefits contribution on a monthly basis to the TML Intergovernmental Employee Benefits Pool. I certify that the expenses listed above qualify as expenses under Section 129, Internal Revenue Code.

Statement of Certification: I certify that I have provided care for _____'s child (children or dependent) from _____ to _____. My charge for this service was _____.	
Name and Address of Provider	Provider's Signature

Tax ID or SS#	