DEPENDENT CARE REIMBURSEMENT VOUCHER

SOC SEC #______________________________ EMPLOYER'S NAME Rhodes College

EMPLOYEE NAME: ________________ ________________ ________ ANNUAL SALARY $________________

Last First MI

SPOUSE'S NAME: ________________ ________________ ________ $________________

Last First MI

To: Pittman Employee Benefits Department

The undersigned participant in the plan requests reimbursement (attach itemized bills, receipts, and invoices for all expenses claimed) in the amounts shown below. If additional space is needed, please use back of form.

1. Name of Dependent(s): ____________ ____________ ____________ ____________ ____________ ____________
2. Period covered: From: ____________ To: ____________
3. Name, address and taxpayer identification number of person providing service and description of service:

____

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____

____

*Amount $________________________

Note The total amount claimed under the Plan for any coverage period must not exceed the lesser of your earned income for the plan year or the earned income of your spouse. If your spouse is either a full-time student or is incapable of taking care of himself or herself, then he or she is deemed to have a monthly income of $200 if there is one child or dependent, and $400 is there are two or more. No payment may be made under the Plan if the service provider is your dependent for federal income tax purposes, or is your child or stepchild and is under the age 19. If services were performed at a daycare center, such center must be a fully licensed, state regulated center providing care for more than six (6) individuals. The code allows you to tax exempt up to $5,000 annually for one or more children if you are a single individual or married filing jointly and up to $2,500 annually for individuals who are married filing separately.

READ CAREFULLY

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the Rhodes College Plan with respect to such expenses. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense which was incurred during the current plan year, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the plan which relate to such expense.

________________________________ ________________________________

Employee's Signature Date

Mail to:
Pittman Employee Benefits
Attn: Billing Department
P.O. Box 111047
Memphis, TN 38111
(901)473-3100 fax (901)473-3266

Revised 03/04/05