CHICAGO THEOLOGICAL SEMINARY

Dependent Care Savings Account Reimbursement Request

Attached is documentation of qualified dependent care expenses that I have incurred for which I am requesting reimbursement from my Dependent Care Savings Account.

The employee's FEIN or the care provider's social security number is included on the attached documentation.

I certify that I have not, and to the best of my knowledge will not, receive reimbursement for these expenses from another source.

The reimbursement amount I am requesting is $ _____.

I understanding that

- The reimbursement amount cannot exceed my actual expenditures as shown on the attached documentation.
- If this amount is greater than my Dependent Care Savings Account balance, my actual reimbursement will be reduced to the amount available for reimbursement.
- The qualified expenses must be for services received from January 1 through December 31 of the current plan year and that I must request reimbursement for those expenses by February of the following year.

_____ _____

Employee's signature Date