Section 125 Cafeteria Plan
Dependent Care Reimbursement Request Form

_____
Employer

_____ _____ _____ _____
First Name MI Last Name SSN

_____ _____ _____ _____
Street Address City State ZIP Code

_____ _____
Phone Email

Instructions: Please utilize this form to request the reimbursement for eligible dependent care expenses under the Section 125 Cafeteria Plan. Please sign and date this form and submit to Bay Bridge Administrators (BBA) along with supporting documentation using the contact information at the bottom of this form.

	Date of Service	Name of Dependent	Name of Provider	Tax ID # os SSN of Provider	Total Expense
1.)					
2.)					
3.)					
4.)					
5.)					
6.)					
7.)					
8.)					

Total: _____

To the best of my knowledge and belief, my statements in this Dependent Care Reimbursement Request Form are complete and true. I understand that these dependent care expenses may not be used to claim any Federal Income Tax deductions or credit (including the Dependent Care Tax Credit). I agree to file IRS form 2441 with my tax return and provide any taxpayer identification number required thereon. I also acknowledge that should the actual annual expenses claimed be less than the amount available, such balance will be forfeited and will remain with the employer at the end of the Plan Year.

_____
Employee Signature Date

Bay Bridge Administrators, LLC., P.O. Box 161630, Austin, TX 78716
Phone: 800-880-2776 Fax: 800-982-8140 www.bbadmin.com
Email: 125@bbadmin.com

BAY BRIDGE ADMINISTRATORS