

**Tax Year 2015**  
**American United Employers, Inc.**  
**Dependent Care**  
**Reimbursement Claim Form**

Employee Name: \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Dependent Name(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Day Care Provider: \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

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

Dates of Services: \_\_\_\_\_ Through \_\_\_\_\_

Charges for Services: \_\_\_\_\_ Per Hr. \_\_\_\_\_ Per Day \_\_\_\_\_ Per Week \_\_\_\_\_

Total Charges: \_\_\_\_\_

\_\_\_\_\_  
(Day Care Provider Signature)

**Employee Certification**

I hereby certify that all items requested to be reimbursed comply with the American United Employers, Inc. Flexible Spending Account and such items have not and will not be covered by any other plan or program of any employer or other person. I further certify that such items will not be deducted or taken as tax credits on my personal federal and state income tax returns for any year. The Company does not accept responsibility for direct payment to any individuals other than the employee.

I understand that this application is only valid for the plan year listed at the top of the application and it does not automatically renew, I must complete a new application for each plan year.

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

Submit this form and any receipts to: Carol Whitacre at [cwhitacre@achcorp.com](mailto:cwhitacre@achcorp.com) or by mail to the address below. Remember to retain a copy for your records.

**NOTICE:**

**All employees participating in a Section 129 Dependent Care Cafeteria Plan are required to file Form 2441 with the IRS by April 15 of the year following your participation in this plan.**