Tax Year 2016

American United Employers, Inc.

Dependent Care
Reimbursement Claim Form

Employee Name: ____ SS# _____-____- ______

Dependent Name(s): ____

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____

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 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.

American United Employers
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