EMAIL TO: WENDYGANN@MURFEEMEADOWS.COM

FAX TO: 205.871.9519

THIS FORM MUST BE COMPLETED TO BE ABLE TO PARTICIPATE IN DEPENDENT CARE

LEON COUNTY SCHOOLS
FLEXIBLE BENEFIT PLAN

Verification of Dependent Care Expenses

NAME OF EMPLOYEE: _____

SOCIAL SECURITY #: _____

This is to certify that my dependent receives childcare/dependent care services from

_____ , Tax I.D.# _____

(Dependent Care Provider)

My cost incurred for the plan year is $ _____ for the following dependent(s):

Dependent(s) Name	Age*
_____	_____
_____	_____
_____	_____

_____ _____

Plan Administrator Employee Signature

_____ _____

Date Date

*Qualifying child must be your dependent and under the age of 13.