

Ft. Zumwalt School District

Expense Affidavit for Dependent Care Flexible Spending (DCFS) Account

Name of Participating Employee _____

Participating Employee's Social Security Number _____

Plan Sponsoring Employer Fort Zumwalt School District

Number of Items Attached _____ Total Dollar Amount Requested \$ _____

Fully complete the following, or attach expense items issued by the provider of services, which indicate the following information:

- Name of care provider _____
- Name of person(s) receiving care _____

- The dates of service (only services actually incurred during the plan year are eligible for benefits) _____
- The total dollar amount charged for services _____
- Care provider's signature _____
- Do not attach cancelled checks, credit card vouchers, or balance due statements – none of which are acceptable as expense verification.
- Submit this affidavit and attached items (if applicable) to:

OLB SYSTEMS
500 Chesterfield Center, Suite 360
Chesterfield, MO 63017
636-532-2103 (voice)
Fax: 636-532-2106

Please assure the readability of all pages and **do not** include a cover sheet.

Benefits cannot exceed your current account balance or annual Dependent Care Flexible Spending (DCFS) election limit and cannot be assigned. By your signature below, you attest that the expenses being submitted are necessary to your employment and were incurred during working hours. You also attest that expenses reimbursed via the DCFS cannot be further claimed for income tax credit or deduction.

Signature of Plan Participating Employee

Date