TAYLOR BENEFIT RESOURCE, INC.
P. O. Box 6580
Thomasville, GA 31758
(229) 225-9943 * Fax (229) 225-9945

SPENDING ACCOUNT CLAIM FORM

NAME	EMPLOYER:		
ADDRESS	SOCIAL SECURITY		
CITY	STATE	ZIP	DAYTIME PHONE

DEPENDENT CARE EXPENSES					
DATE SERVICE	DEPENDENT CARE PROVIDER	TIN OR SOCIAL SECURITY	DEPENDENT	AMOUNT CHARGED	TBR USE
FROM					
TO					
FROM					
TO					

In claiming reimbursement for dependent care expenses, I certify that my spouse and I WILL NOT receive reimbursement in excess of $5,000 from all employer sponsored dependent care spending accounts.

Employee Signature Date

HEALTH CARE EXPENSES					
DATE SERVICE	PAYMENT MADE TO	SERVICE PROVIDED	DEPENDENT	AMOUNT	TBR USE
TOTAL EXPENSES				$	

*Canceled check is not sufficient information

I certify that the expenses listed above qualify for reimbursement and have been incurred and paid by me or by eligible members of my family. These expenses have not been reimbursed by my health care plan or any other health care plan, such as my spouse's. Bills, statements or other evidence of these expenses are attached.

Employee Signature Date