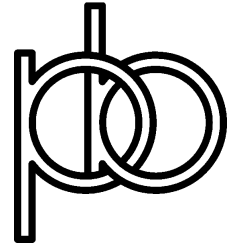


To ensure prompt processing, please submit completed claim forms, along with receipts, to:

Kitt Craighead
National Associates
20325 Center Ridge Road
Cleveland, OH 44116
Phone: 440.333.0222, ext. 235
Fax: 440.333.0221



**Flexible Benefit Plan for UCC Ministries
 Dependent Care Claim Form**

PERSONAL INFORMATION

Social Security number		Employee's name (<i>Last, first, middle</i>)	
Employee's home address	City/State/ZIP	E-mail address @	

As a participant in the Plan, I request reimbursement in the amounts shown below. (*Attach itemized bills, receipts and invoices for all expenses claimed.*)

- a) Name of dependent(s)
- b) Period covered: From _____ through _____
- c) Name, address and, except for certain tax-exempt organizations, the taxpayer identification number of the service provider and description of service:

- d) Amount: \$ _____

NOTE: The total amount claimed under the Plan for any coverage period must not exceed the lesser of your wages or salary for the Plan Year or the wages or salary of your spouse. (If your spouse is either a full-time student or is incapable of taking care of himself or herself, then he or she is deemed to have monthly earnings of \$250 if there is one (1) child or dependent and \$500 if there are two (2) or more.) No payment may be made under the Plan if the service provider is your dependent for federal income tax purposes, or is your child or stepchild and is under age 19.

READ CAREFULLY: You are certifying that all expenses for which reimbursement or payment is claimed by submission of this form were incurred (i.e., services were provided) during a period while you were covered under the Flexible Benefit Plan for United Church of Christ Ministries with respect to such expenses and that such expenses have not been reimbursed, or are not reimbursable, under any other health plan coverage. By signing this form, you are indicating that you fully understand that you are fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim, which is provided by the you, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, you may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid from the Plan which relate to such expense. Please understand that no medical expense tax deduction or credit is permitted for amounts for which reimbursement is made.

Employee signature	Date
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For Plan Administrator use only

Payment authorized: _____
 Amount: \$ _____

Check number: _____
 Date: _____