Dependent Care Flexible Spending Account (DCFSA) Expense Affidavit

Name of Plan Participating Employee_____

Participating Employee's Identifying Number_____

Plan Sponsoring Employer **Collinsville Unit 10 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 the care provider_____
- Name of person(s) receiving care_____
- The dates of service_____
- 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
  3440 Illinois Avenue, St. Louis, MO 63118
  Or fax your claim to 314.664.2262
  Or scan your claim (.pdf format only), naming the file with your last name and the submission date and email to: olbsys@sbcglobal.net.

Benefits cannot exceed your current account balance or annual DCFSA 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 DCFSA cannot be further claimed for income tax credit or deduction.

Signature of Plan Participating Employee_____

Date_____