DATTCO, Inc.
Reimbursement Account Claim Form

Mail to: Accounting
583 South Street
New Britain, CT 06051

Employee name:_____Social Security #_____
Home Address:_____
Home Phone:_____

Medical or Dental Deductibles and Co-payments*					
Other Health Care Expenses* (please list below)					
Services Provided For:	Birth Date	Dates of Service		Description of Expense or Service	Amount
		From	To		

Dependent Care Account*

Services Provided For:	Birth Date	Dates of Service		Description of Expense or Service	Amount
		From	To		
				TOTAL	$

* Please attach documentation that supports these expenses such as an explanation of benefits statements, bills, or itemized receipts. Canceled checks are not acceptable.

I certify: That these expenses are not reimbursable through any other plan of another employer. That the expenses listed above have been incurred by me or my dependents during this plan year and paid by me and qualify for reimbursement (see back of form for a description of eligible expenses). I also understand these expenses no longer qualify as tax deductions or credits. The paid bills and itemized receipts are attached. That appropriate taxpayer information has been obtained from the dependent care providers and that submitted expenses are for dependents who meet the eligibility requirements specified by law.

Employee signature:_____Date_____decap.xls