

Verification Cover Sheet



42826



Participant TASC ID

Client Name

Submit Requests for Reimbursements:

- a. By Fax: 608-661-9601
- b. Or by Mail: TASC
PO Box 7308
Madison, WI 53707-7308

All boxes must be completed. Do not highlight amounts on your receipts.

Request Id#

Request Amount

Service Type

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A Verification Cover Sheet must be accompanied by the required verification documents when returning.

- Please check the box beside each request that has verification documents attached.
- Do not submit the same Verification Cover Sheet more than once. If subsequent submissions are required, print another copy of the Verification Cover sheet, note the related receipts, sign, date, and submit it to TASC.
- A replacement copy of this Verification Cover Sheet can be obtained at www.tasconline.com under the Account Management link.
- Make copies of your original receipts and remit those copies on a standard 8.5 x 11 piece of paper with this Verification Cover Sheet. Retain the original receipts for your records.

To the best of my knowledge and belief, all statements and information provided with this Request for Reimbursement are complete and true. I have read and understand the Terms of Use for my account and certify that I am requesting reimbursement for eligible expenses incurred by eligible persons as allowed under the Terms of Use for my account. For tax-free reimbursements, I certify that these expenses have not been previously reimbursed by any other source, and they will not be submitted as deductible expenses when I file my personal tax returns. I understand I am responsible for retaining copies of all receipts and will provide a copy when required and as allowed by law. I authorize my Accounts to be reduced by the amounts in this Reimbursement Request.

EmployeeSignature(required)

Date / /

FLEX



53536

Reimbursement Form (Dependent Care)



Participant TASC ID

Client Name

Submit Requests for Reimbursement:

a. By Fax: 608-661-9601

b. Or by Mail: TASC
PO Box 7308
Madison, WI 53707-7308

Date of Service:	through:	Request amount	Dependent Name:
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I certify the total cost of qualified adult/child care services below have been provided during the period indicated for the dependents on this form.

Receipts Attached (Select this option if receipts are attached)

Provider signature in lieu of Receipts (Enter Provider name and signature)

Provider Name
□□□□□□□□□□

Provider Signature
□□□□□□□□□□

Date □□ / □□ / □□

To the best of my knowledge and belief, all statements and information provided with this Request for Reimbursement are complete and true. I have read and understand the Terms of Use for my account and certify that I am requesting reimbursement for eligible expenses incurred by eligible persons as allowed under the Terms of Use for my account. For tax-free reimbursements, I certify that these expenses have not been previously reimbursed by any other source, and they will not be submitted as deductible expenses when I file my personal tax returns. I understand I am responsible for retaining copies of all receipts and will provide a copy when required and as allowed by law. I authorize my Accounts to be reduced by the amounts in this Reimbursement Request.

EmployeeSignature(required) □□□□□□□□□□

Date □□ / □□ / □□