DATTCO, Inc. Reimbursement Account Claim Form

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

				Social Secu	urity #	
						•
Home Phone:						
Medical or Dental	Deductibles and Co-pa	vments*				**************************************
	Expenses* (please lis					
Services Provided		Birth Date	Dates of	Service	Description of	Amount
					Expense or Service	
			From	То		
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Dependent Care A Services Provided		Birth Date	Dates of	Service	Description of Expense or Service	Amount
			From	То		

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					TOTAL	\$
	• •		•		xplanation of benefits sta	atements,
bills, or itemized r	eceipts. Canceled che	cks are not	acceptable).		
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certify:	· · · · · · · · · · · · · · · · · · ·				y other plan of another o y me or my dependents	
•				-	sement (see back of form	-
		-			ese expenses no longer	
	as tax deductions or	credits. Ti	ne paid bills	and itemiz	ed receipts are attached	l.
					ned from the dependent	
	· ·		penses are	for depend	lents who meet the eligi	bility
	requirements specifi	ed by law.				