RECEIPT FOR 125 PLAN

(Dependent Care Expense)

_____ _____

EMPLOYEE NAME **DATE**

This is to certify that the below named provider has provided dependent care for the above mentioned employee, for the period _____/_____/_____ through _____/_____/_____, in the amount of $_____. This is in accordance with Klamath Tribal Health & Family Services Policies & Procedures and the Cafeteria Plan Provisions. I certify that the above is true and correct to the best of my knowledge.

_____

EMPLOYEE SIGNATURE

_____ _____

Provider's Name (Print) **Relationship (if any)**

_____ _____

Provider's Signature **Provider's Social Security**

NAMES OF DEPENDENT CHILDREN

1. _____ _____

Name **Birth date**

2. _____ _____

Name **Birth date**

3. _____ _____

Name **Birth date**

4. _____ _____

Name **Birth date**

Revised 11-16-15