DEPENDENT CARE

Reimbursement Claim Form

To expedite your claim:

➤ Provide all appropriate information
➤ Review the Total Dependent Care Expense before printing.

Employer:				
Employee Name:			Social Security Number:	
Phone:			E-mail:	
Dependent Care Expense Clai	ms			
Names of Dependents		eriod Covered To	Name, Address and Taxpayer Identification Number of Service Provider	
			Devided Construction	
Attach a receipt from you daycare provider's signature.	r daycare provide	er, or include the	Provider's Signature:	
			Total Dependent Care Expense Claim*	
	herself, then he or she is de	emed to have monthly ear	of your earned income for the Plan Year or the earned income of your spouse. (If your spoundings of \$200 if there is one (1) child or dependent, or \$400 if there are two (2) or more.) No or stepchild and is under age 19.	
under the Company's Cafeteria Plan with respect understands that he or she alone is fully responsit	to such expenses and that thole for the sufficiency, accura	e medical expenses have cy, and veracity of all infor	nent or payment is claimed by submission of this form were provided during a period while the not been reimbursed or are not reimburse able under any other health plan coverage. The mation relating to this claim which is provided by the undersigned, and that unless an expension of all related taxes including federal, state, or city income tax on amounts paid from the Plan	
Employacia Signatura			Dete	
Employee's Signature			Date	
Send Completed Form with R	Receints Attached	to:		

Employee Benefit Concepts, Inc. P.O. Box 2365 Farmington Hills, MI 48333 claims@employeebenefitconcepts.com Fax-248-855-2454 Phone-248-855-8040 Section 125

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Amount Incurred \$

use is either a full-time o payment may be made

e undersigned was covered undersigned fully se for which payment or which relate to such