Flexible Benefit Plan

Dependent Care Claim Form

EMPLOYER NAME: _____

SECTION I: **Please type or print clearly**

Employee Name: _____ Social Security Number: _____

Address: _____ Group/Employee or ID Number: _____

City/State/Zip: _____ Employment Date: _____

Telephone Number: _____

SECTION II: **Authorization**

I certify that the expenses for which reimbursement is requested under my Flexible Benefit Plan were incurred by myself for my eligible dependents. I will not use expenses reimbursed through the Flexible Benefit Plan as deductions when filing my individual income tax return. I certify that these expenses are not reimbursable under any other plan, including a plan of another employer that covers me, my spouse or another member of my family.

_____ _____

Employee Signature Date

SECTION III: **Dependent Care Provider Information**

Name of Care Provider: _____

Provider Address: _____

Provider's Social Security/ID Number: _____

SECTION IV: **List any dependents for whom you make dependent care payments:**

Dependent Name	Dependent Age	Relationship to Employee

SECTION V: **Dependent Care Benefit**

From Date: _____ To Date: _____ Amount Paid _____

From Date: _____ To Date: _____ Amount Paid _____

From Date: _____ To Date: _____ Amount Paid _____

From Date: _____ To Date: _____ Amount Paid _____

Return completed from to: Dunn & Associates

Mail: PO Box 2369 Columbus, IN 47202-2369 - Fax (812) 378-9967 - Email: info@dunnbenefit.com