EBS
Employee Benefit Services

Dependent Care Reimbursement Claim Form

Employee Name:	Social Security #:	
Street Address:		
City:	State:	Zip:
Home Phone #:	Business Phone #:	
Employer Name:		

Instructions: For all expenses, copies of all receipts must be attached which show who rendered the service, date of the charge and amount of the charge. If you are unable to obtain a valid receipt, please have the provider complete and sign the following:

Name of Dependent(s):		
Date of Service:		Total Charges for Dates of Service:
From:	To:	$
Tax ID or Social Security # of Provider:		

Signature of Provider:	Date:

Employee Certification

I certify that all items requested comply with the Flexible Spending Account Program and such items have not and will not be covered under any other plan or program of any employer or other person. I further certify that such items will not be deducted or taken as tax credits on my personal federal income tax returns for any year. The Plan Administrator does not accept responsibility for direct payment to any individuals other than the employee.

Employee Signature:	Date:

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