Dependent Care Account

Reimbursement Request Form

If Your Provider Gives You A Receipt: Complete this section, and attach a copy of the receipt.

Claimant Name	Date of Care Start Date (within a single Plan Year)	Date of Care End Date (within a single Plan Year)	Provider	Amount	Claim Ref #
					01
					02
					03
					04

OR

If Your Provider Does Not Provide You With A Receipt: Have your Provider complete this section.

Provider Name: ____

Address: ____

City, ST, ZIP: ____

Tax Payer ID/SSN: ______________________

Dependent Care for (Name and Age):______________________________

Dates of Care (within a single Plan Year) Start Date:______________ End Date: ______________

Amount Charged: $______________________

Provider Signature: ______________________________ Date: ____________

Participant Authorization— By submitting this form to Lifetime Benefit Solutions, I certify that the information here is true and correct.

X I authorize the above expenses to be reimbursed from my dependent care account.

X