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