



Dependent Care Account

Reimbursement Request Form



If Your Provider Gives You A Receipt: Completethis section, and attach a copyof 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