

BENEFLEX, INC.

REQUIRED CLAIM CANNOT BE PROCESSED WITHOUT YOUR SIGNATURE

DEPENDENT CARE REIMBURSEMENT REQUEST VOUCHER
To request reimbursement, please complete this form, including appropriate documentation and provide signatures where required. All required fields applicable to your claim must be completed in order to process the claim.

I request reimbursement for the below listed qualified dependent care expenses, I certify that the services for which the expenses have been incurred have been received and the expenses paid. I have included signed copies of their independent provider's charges, which includes the date and amount of charge.

Participant's Signature _____ Date _____

NAME Last First M.I SOCIAL SECURITY NUMBER

HOME TELEPHONE Check Box if Home Telephone has changed

Address City State Zip

E-MAIL ADDRESS:

REQUIRED - COMPLETE ALL SECTIONS

You must attach a bill or receipt showing service dates, cost, and the care provider's tax ID or Social Security number or have the provider sign below in the "Provider Signature" section. Cancelled Checks are not considered sufficient documentation.

Service Date		Name of Service Provider	Provider Social Security or Tax ID #	Dependent Name	Date of Birth	Requested Amount per Dependent
From	To					
						\$
						\$
						\$
						\$
						\$
						\$
						\$

I certify that I provided care as specified above.

Dependent Care Provider's Signature (Necessary only if a receipt is not provided) _____ Date _____

Please mail or fax the completed / signed form to the address/fax below.

BENEFLEX, INC. - P.O. Box 17586 Nashville, TN 37217
Voice (615) 831-0990 - (800) 925-4087 Fax (615) 831-9910 - (800) 449-7501