DEPENDANT CARE ACCOUNT

Reimbursement Claim Form



EMPLOYEE NAME:				SOCIAL SECURITY NO.		
ADDRESS:				CELL PHONE: WORK PHONE:		
EMAIL:				EMPLOYER:	4-601417-000-0	
				_		
CERTIFICATION A						
expenses incurred by 13 or other depende have already receive of these expenses fro tax deductions on n	me for care points that are points that are point these services on any other one personal to	provided by a valid de nysically or mentally es and have not beer plan or party. In add ax return. I understa	ependent care incapable of a previously re ition, the exp and that if ar	am requesting reimbursement for work-te provider to an eligible dependent (for che taking care of themselves) while I was a peimbursed for these expenses and I will not be insert its sought a expense is determined to be ineligible ated income taxes on amounts paid from the provider of the series	ildren under the age of articipant in the plan. I of seek reimbursement twill not be claimed as an responsible for	
Employee Signature:				Date:		
Name of	E EXPENSE CLAIMS (CAREFLE		Name, Address and Taxpayer Identification Number of Amount Paid			
Dependent(s)	From	То		Service Provider		
			-			
**Attach a receipt from your day care provider, or include the dicare provider's signature below.				otal Dependent Care Expense Clair	n	
For Dependent Care lieu of providing a s			e your provid	er sign and date below to certify the expe	enses were incurred in	
Dependent Care Pro	ovider Use Or	ly				
I certify that the de	pendent care	expenses shown abo	ve are valid.			
Dependent Care Provider Signature: Provider ID: Date:						

FAX OR EMAIL CLAIMS TO:

3P Benefit Solutions Fax: 601-715-1855 cliams@3pbenefits.com