DEPENDENT CARE CLAIM FORM

EmployeeName_____SSN(Last4)_____
Address _____

A copy of the provider's bill and paid receipt MUST be attached

Provider Name_____

Address _____

Tax Identification Number _____

License Number _____

Dependent Name _____ Age _____
Relationship _____

Dependent Name _____ Age _____
Relationship _____

Dates of Service _____ to _____

Amount to be reimbursed _____

_____ _____
Employee Signature Date