Boys Hope Girls Hope

REIMBURSMENT REQUEST - FLEXIBLE BENEFITS ACCOUNT
DEPENDENT CARE

1. Complete Parts 1 & 2 in full
2. Attach receipts for all expenses incurred or have provider sign below
3. Submit bills monthly

Submit Claims to: Benefits Manager, National

PART 1 FAILURE TO ANSWER ALL QUESTIONS MAY DELAY PAYMENT

EMPLOYEES NAME (First Name, Middle, Last Name)

STREET ADDRESS | CITY | STATE | ZIP CODE

	DEPENDENT NAME(S)	SEX M = MALE F = FEMALE	D.O.B.	RELATIONSHIP TO INSURED	**DOES THIS DEPENDENT MEET ELEIGIBILITY REQUIREMENTS?	
1.					☐ Yes	☐ No
2.					☐ Yes	☐ No
3.					☐ Yes	☐ No
4.					☐ Yes	☐ No

PART 2 ALL INFORMATION IS REQUIRED PER IRS REGULATION

NAME OF PROVIDER | ADDRESS

TAX I.D. NUMBER OR SOCIAL SECURITY NO. OF PROVIER - MUST BE COMPLETED

Dates of Service: _____ to _____

Total Charges $ _____

I certify the above charges have been incurred.

Receipts are not necessary if Dependent Care Provider signs this section.

_____ _____

Signature of Dependent Care Provider | Date

PLEASE SIGN HERE - ALL CLAIMS

I Certify that dependent care expenses were incurred to allow myself and/or my spouse to be employed outside the home. I understand that dependent care expenses reimbursed from the Dependent Care Account cannot be claimed as a Child Care Tax Credit on my Federal Income Tax Return.

_____ _____

Employee Signature | Date

CLAIMS MUST BE RECEIVED BY THE 5TH FOR PAYMENT
ON THE 15TH OF EACH MONTH

**For dependent eligibility requirements please refer to the 125 Dependent Care Plan Document located on Sharepoint.