Dependent Care Spending Account Continual Reimbursement Form



Partici	pant I	nforn	nation
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Participant Information	on						
Employer Name:				Plan Year:			
Participant Name:					SSN:		
Address:					Birth Date:		
City, State, Zip:			Phone:			Email:	
Dependent / Child Ca	re Pr	ovider Informati	on (p	rovider	's signature requ	ired)	
Dependents' Name(s):	1)			2)		3)	
Birth Date:	1)			2)			3)
Relation to Participant:	1)			2)			3)
Provider's Name:			Provider's Tax ID or SSN:				
Provider's Address:			Provider's Phone:				
Provider Signature: Monthly Dependent C		Expenses				Date:	
List Months in Plan Ye	ar	Monthly Exp	ense		Explanation (if applicable)		
Total Dependent Care Prei	mium:						
be approved thru a continual reimbu Administrator of the cessation or into	rsement perruption ding the	program for any month in w of such services. I have w continual payments or serv	vhich De verified t	ependent (hat the in	Care Services are not formation listed above	rendered. and the i	nding agreement. No reimbursement may It is your responsibility to advise the Plain information attached is true and correct. immediately. Failure to do so could resul
Participant Signature:					Date:		