

Dependent Care "Day Care" Expense Reimbursement Request

Please complete this form and sign and date as shown below. Attach copies of bills prepared by your care providers. Keep the copies of your claim and supporting documentation; we cannot provide copies of claims.

Mail your claim and supporting documents to:

FlexToday, Inc.

Fax Number:

Fax Page # _____ of _____

Personal Information – Must Complete Each Claim	<i>SIGN BELOW – SIGNATURE REQUIRED</i>	
Name of Employer	<p>I, the undersigned, request reimbursement for the expenses submitted herein and certify that these expenses herein not been reimbursed previously and I will not seek reimbursement under any other insurance or benefit plan for these expenses. I further certify that these expenses were incurred (services received, not necessarily paid) during the coverage period by either myself or my eligible dependents for eligible expenses under the Plan as described in the Summary Plan Description and as defined by all applicable state and federal laws. I further acknowledge that it is my responsibility to obtain and report to the IRS the Identification Number of any and all dependent care providers to whom I have paid for services which were submitted for reimbursement under this Plan. I assume the responsibility to maintain substantiating documents for all claims submitted for reimbursement. The Administrator shall have no obligation to any Participant for any act or failure to act, provided the Administrator has acted in good faith in the exercise of its powers in the Plan.</p> <p style="text-align: center;">Sign Here Date Signed</p> <p style="text-align: center;">X _____</p>	
Your Full Name (First and Last)		
Address		
City, State and Zip Code		
Is this a new address? Yes No		
Phone Number		Social Security Number
Your E-Mail Address		

Total Dependent Day Care Expenses Claimed With This Request: \$ _____

Name of Person Receiving Care	Relationship to Employee	Age of the Dependent	Dates the services were provided	Name of the Care Provider	This is my cost for this service
					\$
					\$
					\$

Optional Care Receipt – If your dependent "day care" provider does not provide you with formal bills or receipts, you can have your Care Provider complete this optional receipt to document your expense.

Name of Provider	Dates of Services	Amount Paid \$
Signature of Care Provider X	Date Signed	Provider Tax ID/SSN