Mail or Fax Claim To: **Benefit Extras, Inc.**
P.O. Box 1815
Burnsville, MN 55337
Phone: (952) 435-6858

Dependent Care Reimbursement Form
Fax: (952) 435-8435

Employer Name: _____

Employee Name: _____ SS# _____

Dependent Name(s): _____ Age(s): _____

_____ _____

_____ _____

Day Care Provider: _____ Fed. ID# _____

Address: _____

_____

_____

Dates of Service: _____ Through _____

Charge for Service: _____ Per Hr. _____ Per Day _____ Per Week _____

Total Charges: _____

_____
(Day Care Provider Signature)

EMPLOYEE CERTIFICATION

I hereby certify that all items requested to be reimbursed comply under the Plan and such items have not and will not be covered by any other plan or program of any employer or other person. I further certify that such items will not be deducted or taken as tax credits on my personal federal and state income tax returns for any year. The Employer does not accept responsibility for direct payment to any individuals other than the employee.

_____ _____
Employee Signature Date