DEPENDENT CARE REIMBURSEMENT REQUEST FORM

Employer Name: _____

Employee Name: _____ **SS# or ID#:** _____

Address: _____ **Telephone #:** _____

City: _____ **State:** _____ **Zip:** _____ **Is this a change of address?** Y or N

Dependent Care Account (DCA)

Name of Day Care Provider	Dates of Service		Dependent's Name	Date of Birth	Amount of Expense
	From	To			
					$
					$
					$
Total amount requested from your **DCA**:					$

Provider Signature: _____ **Provider SSN# or Tax ID:** _____

Signature not required if signed receipt or Day Care Center statement is attached. Altered receipts cannot be accepted.

Please fill out all information completely. If more space is needed, list additional requests on a separate page. Please include all