Dependent Care Expense Reimbursement Claim Form

Employer: ____

Participant's Name: _______________________________________SSN: ____________________

Change of Address Information:____

____

Name of person(s) receiving care: Relationship:

____

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____

Date of Service: ______________________________ Recurring every: ___________________________

Amount to be reimbursed: _______________________

Provider's name and address:

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____

Provider's signature: ____

(If you wish to use this form as a receipt, please have your provider sign on the line provided.)

Note: The dependent care expenses that you are claiming on this form cannot be reimbursed until the ending date of service. The IRS requires that the entire expense be incurred before it can be reimbursed.

IMPORTANT: You must attach third party proof of your claim if your provider does NOT sign the line above. Proof needs to be an itemized bill or receipt signed by your provider.

You must also report your provider's tax identification number on Form 2441 when you file your income tax return.

READ CAREFULLY: The undersigned plan participant certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period in which the undersigned was covered under the employer's plan with respect to such expenses. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim provided by the undersigned. Unless an expense for which payment or reimbursement is claimed is a proper expense under the plan, the undersigned may be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the plan which relate to such expense.

____ ____________________

Participant's Signature Date

Mail or fax to: Eagle Ridge Services
PO Box 2640
Sioux City, IA 51106-0640
Scan to: claims@eagleridgeservices.com

Phone: 712-274-6725
Toll Free: 800-301-6692
Fax: 712-274-6726