Dependent Care Reimbursement Account
Dependent Care Contract & Reimbursement Form

Employee Name:____ **Soc Sec #:** _______________________

Employer: ____

Home Address: ____

City: _________________________________ State: _____________ Zip: ___________________

Dependent Names: ____

Dependent Care Provider: ____

Address: ____ **Tax ID** #: _______________________

City: _________________________________ State: ____________ Zip: __________________

To submit a single claim for your full annual Dependent Care election, complete this section:

This is an agreement made between the above listed parties for dependent care services for the period from ______/______/______ to ______/______/______ , in the amount of $______________ for the purposes of Flexible Spending Account reimbursement. It is also agreed that services provided in excess of the amount shown will be paid for directly by the employee.

____ ____________ ____ ____________

Daycare Provider Signature Date Employee Signature Date

To submit a claim for a portion of your Dependent Care election, complete this section:

Dates of Service:

1. ______/______/______ to ______/______/______ Amount: $______________
2. ______/______/______ to ______/______/______ Amount: $______________
3. ______/______/______ to ______/______/______ Amount: $______________

To the best of my knowledge and belief, my statements in the requested expenses are complete and true. I am requesting reimbursements only for eligible expenses incurred during the applicable plan year for myself and my eligible dependents. I certify that these expenses have not been and will not be reimbursed under another employer sponsored benefit plan and will not be claimed as an income tax deduction. Also, I certify that these expenses have not been previously reimbursed under this plan. I authorize that my plan account will be reduced by the amount of the requested reimbursement.

____ ____________

Employee Signature Date

***** You MUST attach receipts from the provider for the amount and dates shown.***

Completed form should be faxed to: 866-511-5503
Or it can be e-mailed to: claims@vantageflex.com
Or it can be mailed to: Vantage Flex, LLC
413 10th Ave
Menominee, MI 49858

If Faxing:
Number of pages (including this one): ___________