## **Dependent Care Claim form**



P.O. Box 1513 Cabot, AR 72023 Phone: 501-941-5956 Fax: 877-641-5956 info@consolidatedadmin.com

Employer			info@consolidatedadmin.com www.consolidatedadmin.com		
SSN					
First Name					
Last Name:		provided, if	Please Itemize each expense on form provided, if you have more expenses than		
Address:  Check here if new addr		form allows	form allows please attach separate form.		
Check here if new addi					
Date of Service	Dependent Name & Age	Provider Name, Tax Id & Address	Amount		
	+				

		Total Expense			
Please have your day care provider sign this form on the line below or provide a receipt for the services					

Signature of day care provider:

I certify that the statement and information on this claim form are accurate and true.

I also certify that I am claiming reimbursement for only eligible expenses incurred during the plan year and are for eligible participants.

I certify that these expenses have not been or will not be reimbursed from any other source.

I assume all liability for taxes and penalties out of any disallowed contribution/reimbursement					
Signature:		Date:			
		•			