Dependent Care Flexible Spending Account Reimbursement Request Form

To: Flexcorp	E-Mail: claims@flexcorp.com Fax: (866) 238-8224
Employee's Name:	Email Address:
Employer's Name:	Date of Request:
Western Kentucky Identification Number:	Daytime Phone Number:

Instructions: You may use this as a fax cover sheet. Please print or type and complete all items in the table above. In order to receive dependent care reimbursement, you have two choices. (1) Fill out all items in the Dependent Care Expenses section and attach a receipt of your payment, **OR** (2) Fill in your dependent's name, age, date of service and the requested amount, and have your Day care provider fill out the **Affidavit of Dependent Care Provider**. You must sign and date this form and attach any corresponding receipts in order for us to process this claim. You have permission to photocopy this form.

Dependent Care Expenses

Dependent's Name	Age	Date of Service From	To	Requested Amount
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
		Total:		$0.00

Affidavit of Dependent Care Providers

I have provided adult/child care for _____ age, _____ for the period beginning _____
And ending _____. Services were provided by _____ for a fee of $ _____

Signature of Provider	Tax ID# or SS	Date

I, the undersigned, hereby certify that the above listed expenses have not been previously reimbursed from my Dependent Care Flexible Spending Account, nor are the reimbursable from any other source. I hereby authorize FlexCorp to obtain necessary information from all physicians, hospitals, employers and all other agents in order to adjudicate the claim for reimbursement under the Benefit Plan established by my employer.

Employee Signature _____ **Date** _____