Continual Reimbursement Request Form / Dependent Care Authorization

Employer Name:_____ Work Phone (___)_____
Participant Name:_____ SSN_____
Participant Address:_____ Home Phone(___)_____
_____

Provider of Service Information:

Provider Name	Tax ID or SSN	Nature of Service	Dep Name	DOB	Cost of Service
					$
					$
					$
					$

Participant Statements

Dependent Care (if applicable):

The dependent(s) for whom care is provided spends at least eight hours per day in my household. All care outside my home is performed by a Qualified Provider of Service. If my spouse is not employed he/she is a full time student attending _____ _____ from _____ to _____, or is incapacitated and incapable of employment. I have reviewed the option of taking tax credit for dependent care expenses (IRS Form 2441).

Tax Liability:

I verify that the information listed above is true and correct. I understand that if any changes regarding any of the above occur, that the Plan Administrator must be notified immediately. Failure to do so could result in additional taxes and or penalties for which I would be responsible.

Participant Signature _____ Date_____

Request for Continual Reimbursement [ ] DEPENDENT CARE [ ] ORTHODONTIA

The expenses listed above are expenses for which I am obligated by agreement to the provider of services. Please enter this claim in its entirety to be paid on a continual basis as services are performed. Starting_____ Ending_____ # of Payments____ Payment Amt $_____ Total Amount $_____

Participant Signature_____ Date_____

Affirmative Statement From Provider

I, _____am Providing _____ Services To_____
(Name Of Provider) (Type of Service) (Employee)

For _____ For Dates: From _____ To _____ For a fee of $_____ Per _____
(Person Receiving Service)

_____ _____
Name of Provider Tax ID # or SSN

_____ _____
Signature of Provider Date