



**AUTOMATIC DEPENDENT CARE REIMBURSEMENT CLAIM FORM**

Dear Provider of Dependent Care Services:

The person named below is a participant in an employer sponsored Dependent Care Reimbursement Plan. Through this Plan, dependent care expenses are deducted from this participant's paycheck on a pre-tax basis.

This participant has requested regularly scheduled payments each month for reimbursement of dependent care services based on their employer's payroll cycle.

The IRS requires that proof of services (a receipt) be provided by a third party (the provider of services).

By completing and signing the Provider of Services information below, you acknowledge that you are providing services for this participant, as stated.

**Provider Information:**

I have read the above and understand and verify that the participant listed below receives daycare services, for which he/she pays \$\_\_\_\_\_ each month.

\_\_\_\_\_  
Provider Name Phone No.

\_\_\_\_\_  
Provider Address City State Zip

\_\_\_\_\_  
Provider Signature Date

\*\*\*\*\*

**To Be Completed by Employee:**

\_\_\_\_\_  
Employee Name ID #

\_\_\_\_\_  
Employer Name

Dependent Care Reimbursements will be disbursed: a) based on your payroll reductions, or b) based on the schedule your employer has chosen. I understand that it is my sole responsibility to inform Sheffield, Olson & McQueen, Inc. should daycare services cease, or my monthly expenses fall below the amount shown above. I accept full liability for timely notification of any changes.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

11/13/2008

**NOTE: All reimbursements will be paid to the employee..**