FLEX source, LLC.
Flexible Benefits Specialists

Monthly Dependent Care Claim Form
Flexible Spending Account

Claim Request

As a participant in my employer's Section 125 Plan, I hereby request FlexSource to reimburse me for:

Date			Weekly Amount
Week 1	___/___	to ___/___	$ _____
Week 2	___/___	to ___/___	$ _____
Week 3	___/___	to ___/___	$ _____
Week 4	___/___	to ___/___	$ _____
Week 5	___/___	to ___/___	$ _____
		TOTAL MONTHLY AMOUNT	**$** _____

Employee Name: _____

Social Security Number: _____

Company Name: _____

I incurred the expenses for which reimbursement is requested on behalf of my dependent for properly reimbursable items under Section 125 of the Internal Revenue Code.

_____

Signature of Employee Date

- ***Claim payments are processed on a weekly basis every Wednesday.***
- ***Dependent Care Claims will be reimbursed to the participant up to the balance available in the account.***

Certification from Provider

We certify that we are providing Dependent Care Services for the above employee for the month of

_____ in the year of _____ for _____
(Child's name)

_____

Name of Day Care Provider

Federal ID # or Social Security # _____

Signature of Day Care Provider _____ Date _____

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