DEPENDENT CARE RECEIPT FORM

THIS IS NOT A CLAIM

Dear Dependent Care Provider:

The person named below is a participant in an employer-sponsored Dependent Care Flexible Spending Account. The participant is requesting reimbursement from this pre-tax account for qualified dependent care expenses paid to you, the dependent care provider.

Employer ____________________ Plan Year ____________________

Employee Name (Last Name, First Name, MI) (Please Print) ____________________ Employee ID ____________________

The IRS requires that proof of service (a receipt) be provided by the care provider. Please use this form as that receipt by completing the Provider Information section and signing below.

PROVIDER INFORMATION:

Care Provider Name ____________________ Tax ID or Social Security Number ____________________

Date(s) of Care Provided ___________ To ____________

Dependent Name(s) Receiving Care ____________________

I verify that all information contained on this form regarding my dependent care services provided to the employee named above is accurate, and applicable amounts have been paid.

Care Provider Signature: ______________________________ Date: ____________________

Return completed form to Surency at email: flex@surency.com - fax: 316-272-4841
or mail: P.O. Box 789773, Wichita, KS 67278-9773

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