Dependent Day Care
Service Agreement & Claim Form

Service Agreement made on this _____ day of _____ by and between the Participant and the Service Provider identified below for the care of the Dependent named below:

Participant Name	Social Security Number		Telephone Number
Participant Address	City	State	Zip

Dependent Name	Social Security Number	Date of Birth

Day Care Service Provider Name	Tax I. D. Number		Telephone Number
Day Care Service Provider Address	City	State	Zip

Services shall begin on: _____ and continue until: _____

Fees for services shall be: $ _____ per _____

By their signatures below, the above named parties hereby:

- attest to the accuracy of the above information to the best of their knowledge and belief;
- authorize the release of information contained herein to FlexComp Administration Services, Inc. as needed to qualify the above expenses as eligible for reimbursement under my employer's Dependent Day Care Assistance Plan;
- agree to provide written documentation of expenses when requested by FlexComp.

_____ _____
Participant/Payor Signature Date

_____ _____
Authorized Signature for Service Provider Date

Employee Claim Statement: I hereby certify that I am a participant under the following plan:

_____ Dependent Day Care Assistance Plan
Enter Your Employer Name Above

I further certify that:

- the total amount claimed for the plan year does not and will not exceed the lesser of my earned income or my spouse's earned income for the plan year;
- all expenses for which reimbursement is claimed on this form were incurred during a period while I was covered under the above named Employer's Cafeteria Plan with respect to such expenses, and reimbursement will not be sought from other sources. I fully understand that I alone am responsible for the sufficiency, accuracy, and veracity of all information relating to this claim;
- I may be liable for payment of all taxes on amounts paid from the plan unless the expense for which reimbursement is claimed is a proper expense under the Plan.

_____ _____
Employee Signature **Date**

Sender's Name: _____

Sender's Phone #: _____

Claims By Fax:
Fax to: 251-666-0101 (Local Mobile); or
1-800-FAXFLEX (1-800-329-3539
Please do not send separate cover sheet
Problems transmitting? Call FlexComp 251-666-1999