


# DEPENDENT CARE REIMBURSEMENT REQUEST

 <p style="font-size: 1.2em; margin: 0;"><b>BENEFIT SERVICES™</b></p> <p style="font-size: 0.8em; margin: 0;">A DIVISION OF MEDICAL MUTUAL SERVICES, LLC</p>	<p><b>SUBMIT CLAIMS TO : BENEFIT SERVICES</b>  <b>P.O. BOX 4430</b>  <b>AKRON, OHIO 44321</b></p> <p>phone (330)666-0337    toll free 800-367-3762 ext 14535          fax (330)666-2845</p>		
<b>**EMPLOYEE INSTRUCTIONS**</b>			
<b>1. COMPLETE PARTS A &amp; B IN FULL</b>			
<b>2. ATTACH RECEIPTS FOR ALL EXPENSES INCURRED</b>			
<b>PART A                    FAILURE TO ANSWER ALL QUESTIONS MAY CAUSE DELAY IN PAYMENT</b>			
ADDRESS CHANGE ? (PLEASE CIRCLE)    YES    NO			
EMPLOYEE NAME (FIRST, MIDDLE, LAST)	STREET ADDRESS                    CITY                    STATE                    ZIP CODE		
DATE OF BIRTH	EMPLOYER	SOCIAL SECURITY NUMBER	
DEPENDENT NAME(S)	SEX (PLEASE CIRCLE)	DATE OF BIRTH	RELATIONSHIP TO EMPLOYEE
1	MALE   FEMALE		
2	MALE   FEMALE		
3	MALE   FEMALE		
4	MALE   FEMALE		
<b>PART B                    PER IRS REGULATION, ALL INFORMATION BELOW IS REQUIRED</b>			
NAME OF PROVIDER	ADDRESS		
PROVIDER'S TAX I.D. NUMBER OR SOCIAL SECURITY NUMBER :			
PLACE WHERE CARE RENDERED (PLEASE CIRCLE)			
EMPLOYEE'S HOME	LICENSED FACILITY	OTHER	
NUMBER OF CHILDREN BEING CARE FOR BY PROVIDER (INCLUDING YOUR DEPENDENTS) :			
IF MORE THAN 6 CHILDREN - IS FACILITY LICENSED?    YES    NO    (PLEASE CIRCLE)			
RELATIONSHIP OF PROVIDER TO EMPLOYEE    (PLEASE CIRCLE)			
NONE    PARENT    DEPENDENT CHILD *BIRTH DATE: ____/____/____	OTHER FAMILY MEMBER		
*PLEASE NOTE: THE IRS REQUIRES DEPENDENT PROVIDER TO BE AT LEAST 19 YEARS OF AGE			
DATES OF SERVICE    ____/____/____	THRU    ____/____/____	TOTAL CHARGES: \$ _____	
<p><b>YOUR PLAN HAS ADOPTED A 2 1/2 MONTH GRACE PERIOD. YOU <u>MUST</u> INDICATE FROM WHICH PLAN YEAR YOU WISH TO BE REIMBURSED, OTHERWISE, FUNDS WILL BE REIMBURSED FROM THE PRIOR YEAR</b></p> <p style="text-align: center;"><b>School Year 2008/2009</b> _____ <b>Schc School Year 2007/2008</b> _____</p>			
<p>I certify that dependent care expenses were incurred to allow myself and/or spouse to be employed outside the home. I understand that dependent care expenses form my Dependent Care Account cannot be claimed as a Child Care Tax Credit on my Federal Income Tax Return.</p>			
<p>_____</p> <p style="text-align: center;"><b>EMPLOYEE SIGNATURE</b></p>	<p>_____/_____/_____</p> <p style="text-align: center;"><b>DATE</b></p>		