

DEPENDENT CARE ASSISTANCE PLAN - AUTOMATIC CLAIM REQUEST

The IRS requires that proof of services be provided to be reimbursed for Dependent Care Flex expenses. By completing this form the participant and his/her day care provider are certifying that the participant is incurring on-going day care expenses. The completion of this form will allow reimbursements to the participant on a per pay period basis. Claims will not be processed if the form is not completed and signed by both the participant and his/her provider.

Participant / Employee Information

Name of Participant: _____ Last Four Digits of SSN: _____
Address: _____
City: _____ State: _____ Zip: _____
Name of Dependent: _____ Age of Dependent: _____
Participant's Employer: _____

Declaration of Services

I request reimbursement for qualified Dependent Care Services for the indicated timeframe.

I certify that the services will be provided between the following dates:

From: _____ To: _____
START DATE OF SERVICES END DATE OF SERVICES

Total Amount for this period is: \$ _____

I agree that if the amount changes for any reason and the expenses are not incurred as scheduled
I will notify American Benefits Group in writing immediately.

Employee Signature: _____ Date: _____

Care Provider Information

Provider Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Federal Tax ID #: _____

Provider Signature: _____ Date: _____

Fax Toll Free: 866-EZE-FLEX (866-393-3539) or email to claims@amben.com

(No Fax Machine? Mail to: American Benefits Group, P.O. Box 1209, Northampton, MA 01061-1209)