DEPENDENT CARE REIMBURSEMENT REQUEST

SUBMIT CLAIMS TO : MUTUAL HEALTH SERVICES
P.O. BOX 5700
MZ: 04-2W-8610
CLEVELAND, OHIO 44101

phone (330)666-0337 toll free 800-367-3762 ext 14535
fax (330)666-2845 flex@mutualhealthservices.com

****EMPLOYEE INSTRUCTIONS****

1. COMPLETE PARTS A & B IN FULL
2. PLEASE HAVE YOUR DAYCARE PROVIDER SIGN THE ITEMIZATION OF CHARGES

WE CANNOT CONSIDER FUTURE DATES OF SERVICE.

PART A FAILURE TO ANSWER ALL QUESTIONS MAY CAUSE DELAY IN PAYMENT

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			

PART B PER IRS REGULATION, ALL INFORMATION BELOW IS REQUIRED

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

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: $_____

YOUR PLAN HAS A 2 1/2 MONTH GRACE PERIOD. ANY CHARGES INCURRED WITHIN THE GRACE PERIOD WILL BE PROCESSED FROM ANY EXISTING PRIOR YEAR FUNDS FIRST.

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.

_____ _____/_____/_____

EMPLOYEE SIGNATURE DATE