EBSO
Expert Benefit Solutions

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AUTOMATIC DEPENDENT CARE REIMBURSEMENT CLAIM FORM

Dear Provider of Dependent Care Services:

The person named below is a participant in an employer sponsored Dependent Care Reimbursement Plan. Through this Plan, dependent care expenses are deducted from this participant's paycheck on a pre-tax basis.

This participant has requested regularly scheduled payments each month for reimbursement of dependent care services based on their employer's payroll cycle.

The IRS requires that proof of services (a receipt) be provided by a third party (the provider of services).

By completing and signing the Provider of Services information below, you acknowledge that you are providing services for this participant, as stated.

Provider Information:

I have read the above and understand and verify that the participant listed below receives daycare services, for which he/she pays $_____ each month.

_____
Provider Name Phone No.

_____
Provider Address City State Zip

_____
Provider Signature Date

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To Be Completed by Employee:

_____
Employee Name ID #

_____ Primary E-mail address _____
Employer Name

Dependent Care Reimbursements will be disbursed: a) based on your payroll reductions, or b) based on the schedule your employer has chosen. I understand that it is my sole responsibility to inform EBSO, Inc. should daycare services cease, or my monthly expenses fall below the amount shown above. I accept full liability for timely notification of any changes.

Employee Signature_____ Date_____

NOTE: All reimbursements will be paid to the employee.

Please send completed and signed copy to customerservice@ebsobenefits.com or to the fax number or mailing address at the top of this form. Questions, contact EBSO, Inc. Customer Service at 651-695-2500 or 800-486-7664.

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