



2007 DEPENDENT DAYCARE CLAIM FORM
SECTION 125 – FLEX REIMBURSEMENT CLAIM FORM

**HOW TO FILE
A CLAIM**

- 1.) Reimbursement can only be made with the submission of one of the following:
 - a. this form completed with the Provider of Care’s signature as indicated below; or,
 - b. itemized receipts completed by the Provider of Care attached to this claim form, or;
 - c. cancelled checks attached to this claim form.

2.) Mail your claim to: **Benefit Systems & Services, Inc** Fax: 630-203-4580
760 Pasquinelli Drive Phone: 800-423-1841
Suite 320 Email via our Website
Westmont, IL 60559 www.benefit-sys.com

ABOUT YOU

Employer’s Name SUNWEST EMPLOYER SERVICES/
 Your Name _____
 Your Address _____

 Your Alternate ID or Social Security Number _____

**DEPENDENT
INFORMATION**

Name:	Date of Birth:

**DAYCARE
PROVIDER
INFORMATION**

Name: _____ Social Security/Tax ID#: _____

Date of Service:	Amount:

Provider of Care Signature

**PAYMENT
AUTHORIZATION**

I request payment from my Reimbursement Account for the expenses itemized and attached, and understand that the expenses reimbursed cannot be claimed on my personal income tax return.

Employee Signature _____ Date _____