



## DEPENDENT CARE CLAIM FORM

EmployeeName \_\_\_\_\_ SSN(Last4) \_\_\_\_\_  
Address \_\_\_\_\_

**A copy of the provider's bill and paid receipt MUST be attached**

Provider Name \_\_\_\_\_

Address \_\_\_\_\_

Tax Identification Number \_\_\_\_\_

License Number \_\_\_\_\_

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Dependent Name \_\_\_\_\_ Age \_\_\_\_\_  
Relationship \_\_\_\_\_

Dependent Name \_\_\_\_\_ Age \_\_\_\_\_  
Relationship \_\_\_\_\_

Dates of Service \_\_\_\_\_ to \_\_\_\_\_

Amount to be reimbursed \_\_\_\_\_

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date