Dependent Care Claim Form

Employee Benefit Concepts, Inc.
A Group Resources Company
P.O. Box 2365
Farmington Hills, Mi 48333-2365
(248)855-8040 Fax: (248)855-2454

Employer _____ Employee Name _____

Last 4 digits of Social Security Number _____ E-mail Address _____ Phone _____

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Dependent Care Expense Claims

Name of Dependents	Period Covered From	To	Name, Address, and Taxpayer Identification Number of Service Provider	Amount Incurred
			➡**Total ***	**$**
➡ Attach a receipt from your daycare provider, OR include the daycare provider's signature.			➡**Provider's Signature:**	

*NOTE: The total amount claimed under the Plan for any coverage period must not exceed the lesser of your earned income for the Plan Year or the earned income of your spouse. (If your spouse is either a full-time student or is incapable of taking care of himself or herself, then he or she is deemed to have monthly earnings of $200 if there is one (1) child or dependent, or $400 if there are two (2) or more.) No payment may be made under the Plan; if the service provider is your dependent for federal income tax purposes; or is your child or stepchild and is under age 19.

Read Carefully: The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the Company's Cafeteria Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

Employee's Signature _____ Date _____

Send Form with Receipts attached to: Employee Benefit Concepts, Inc. ● P.O. Box 2365 ● Farmington Hills, MI 48333 ● flexclaims@groupresources.com ● Phone 248-855-8040 ● Fax 248-855-2454