



ENLOE MEDICAL CENTER
FLEXIBLE SPENDING ACCOUNT
DEPENDENT CARE REIMBURSEMENT PLAN CLAIM FORM

Social Security No.: _____ Employee No.: _____

Participant's Name: _____
Last First Middle

PROVIDER STATEMENT

- 1. Name of Dependent(s) _____
2. Period Covered: From _____, 20____ Through _____, 20____
3. Name _____ SSN or IRS # _____
Address _____ Service is custodial child care only: _____
City, State,zip _____ Dependent Is: Child under age 13 _____ OR
Requires care due to physical of mental capacity _____
Amount \$ _____

Your dependent care provider must sign the claim form verifying charges are incurred or you must submit a receipt from the provider for services rendered:

I certify that the above services have been rendered for the time period indicated:

Signature of Provider _____ Date _____

READ CAREFULLY

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the Plan's Flexible Spending Account with respect to such expenses. 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 _____

Please send claims to: FLEX-CARE
Administered By Keenan HealthCare
P.O. Box 2744
Torrance, CA 90509
Phone: (800) 653-3626 ext 3614
Fax: (310) 212-3381
