ASI ADMINISTRATION SPECIALISTS INC. • 6370 Normandy Street • Saginaw, MI 48638
• **Phone:** (989) 793-8844 | 1-800-228-3544 • **Fax:** (989) 799-3692
• **Web:** www.ASI401K.com

DEPENDENT CARE CLAIM REQUEST

ATTENTION: Employees participating in a Flexible Benefit Plan with a Dependent Care Flexible Spending Account. Use this Claim Form, properly completed and signed by the Care Provider, when submitting a claim for reimbursement.

EMPLOYER_____

EMPLOYEE NAME_____SS#_____

EXPENSES PAID FOR DEPENDENT(S) LISTED BELOW.

DEPENDENT'S NAME RELATIONSHIP AGE (as of date of service)

_____

_____

_____

Name of Provider_____#_____
(F.E.N. or SS#)

I hereby certify that the following amounts were paid by the above named individual in payment for Dependent Care Expenses for the Dependent(s) named above for dates of care indentified below.

DATES OF SERVICE: FROM_____ TO_____ $_____

FROM_____ TO_____ $_____

FROM_____ TO_____ $_____

FROM_____ TO_____ $_____

FROM_____ TO_____ $_____

FROM_____ TO_____ $_____

TOTAL AMOUNT PAID $_____

To the best of my knowledge and belief, my statements in this Request for Reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants. I certify that these expenses have not been previously reimbursed under this or any other benefit plan and will not be claimed as an income tax deduction. I authorize my flexible spending account be reduced by the amount requested.

Employee's Signature_____Date:_____

Signature of Care Provider_____