



DEPENDENT CARE RECEIPT FORM (THIS IS NOT A CLAIM)



Dear Dependent Care Provider:

The person named below is a participant in an employer sponsored Dependent Care Flexible Spending Account. The participant is requesting reimbursement from this pre-tax account for qualified dependent care expenses paid to you, the dependent care provider.

Employer

Plan Year

Employee Name (Last Name, First Name, MI) (Please Print)

Employee ID

The IRS requires that proof of service (a receipt) be provided by the care provider. Please use this form as that receipt by completing the Provider Information section and signing below.

Provider Information

Care Provider Name

Tax ID or Social Security Number

Date(s) of Care Provided _____ To _____

Dependent Name(s) Receiving Care

I verify that all information contained on this form regarding my dependent care services provided to the employee named above is accurate, and applicable amounts have been paid.

Care Provider Signature _____

Date _____

**Return completed form back to Surency at email: flex@surency.com - fax: 316-272-4841
or mail: P.O. Box 789773, Wichita, KS 67278-9773**

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