Reimbursement Request for Dependent Care Expenses

FlexChoice: A flexible benefits plan

Mail this request (and any supporting documentation) to Everence FlexChoice or fax to (574) 537-6642.

Group name ____________________

Employee name ____________________ Social Security number ____________________

If recent change in address, please update.

Address ____________________
street city state ZIP

Dependent care expenses

Dates of Service	Name of Dependent Receiving Care	Name of Provider	Requested Amount
		Total	

I understand and agree that the total amount of dependent care reimbursement for the calendar year **cannot exceed the lesser of $5,000 (if married and filing a joint return or single and filing as head of household) or $2,500 (if married and filing separate tax returns), my earned income, or my spouse's earned income.** I understand that dependent care expenses cannot be claimed as a dependent care tax credit on my personal income tax return or reimbursed by any other source.

I fully understand and agree that, by signing this form, I assume responsibility for any liability which arises out of submission or payment of a request for reimbursement. I will solely be liable for any penalties or damages as a result of an inappropriate claim being filed.

Everence Insurance Company
1110 North Main Street
Post Office Box 483
Goshen, IN 46527
www.everence.com
Toll-free: (800) 348-7468
T: (574) 533-9511

____
Employee's signature

____
Date

Please attach a signed receipt from your provider or complete the receipt below.

- -

Receipt for dependent care

I, ____________________, have provided dependent care for ____________________
name of provider name of dependent

on the following dates ____________________ and have received ____________________ in payment.
amount

____
Signature of dependent care provider

____
Date

2100832