# FLEXIBLE BENEFIT PLAN – DEPENDENT CARE CLAIM FORM

**NAME** (as it appears on payroll) _____ **SOCIAL SECURITY NUMBER** _____

**Attach itemized receipts from Dependent Care Provider - or - Provider may complete and sign below**

| SERVICE FROM | SERVICE TO | DEPENDENT'S FULL NAME | SERVICE PROVIDED | CHARGES |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**(LIST ADDITIONAL DATA ON REVERSE)**

**PROVIDER'S NAME** _____ **ADDRESS** _____

**CITY** _____ **STATE** _____ **ZIP CODE** _____

_____ _____ _____

**PROVIDER'S SIGNATURE** **TAX ID #** **DATE**

I certify that expenses submitted under this claim:

1. Are for the care of an eligible dependent(s).
2. Are for services provided by an eligible provider(s).
3. If married, the expenses enabled my spouse to be gainfully employed, or to look for work or are for services provided during months my spouse was an eligible disabled spouse or a full-time student and the expenses do not exceed the lesser of my or my spouse's income.
4. Have not been submitted previously and are for the current plan year.

_____ _____

**Employee Signature** **Date**

**Please send to**: Werntz & Associates, Inc.
Cafeteria Department
P.O. Box 5606
Shreveport, LA 71135-5606
Fax: 318-798-3206, E-mail: cafeteria@werntz.com