



# Dependent Care Reimbursement Request Form (DAY CARE)

Submit claims to: Professional Benefits Services or Fax (616) 285-9965  
Flexible Spending Department Total number of pages \_\_\_\_\_  
2959 Lucerne SE Suite 205  
Grand Rapids, MI 49546 or Email claims to:  
[flex@professionalbenefits.net](mailto:flex@professionalbenefits.net)

For questions please call: (616) 285-2480 or (800) 732-3412

### Employee Instructions:

1. Reimbursement form must be complete and clear. Failure to answer any questions or provide proper documentation may delay payment.
2. All receipts must have the name of the dependent(s), date of service, a provider, and the amount of the charge.
3. You must provide bills from your dependent care provider or other evidence that the expenses were incurred and paid. Cancelled/Copied checks will not be accepted.

Employer\Place of employment: **CHARLOTTE PUBLIC SCHOOLS** Department \_\_\_\_\_

Employee Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Change of Address

Employee Number \_\_\_\_\_ or Social Security Number (Optional) \_\_\_\_\_

### Provider Information:

Name of Provider \_\_\_\_\_ SS# or Tax ID of provider \_\_\_\_\_

Address of Provider \_\_\_\_\_

Dates of Service: From \_\_\_\_\_ Through \_\_\_\_\_

Dates of Service: From \_\_\_\_\_ Through \_\_\_\_\_

Name of Dependents:	Age (under 13)
1 _____	_____
2 _____	_____
3 _____	_____
4 _____	_____
5 _____	_____

**TOTAL REIMBURSEMENT REQUESTED** \$ \_\_\_\_\_

To the best of my knowledge and belief, this Reimbursement Request Form is complete and true. The expense is for my dependent. I certify that the receipts are for a dependent as defined in the plan. I certify that I have not been reimbursed previously for these expenses. I understand that these expenses may not be used to claim any federal income tax deduction or credit (including the dependent care tax credit). I agree to file IRS Form 2441 with my tax return and provide any taxpayer identification number required thereon.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date