Dependent Care Spending Account
Continual Reimbursement

THE ADVANTAGE GROUP

Employee Information

Full Name: _____ SSN: _____

Mailing Address: _____ Daytime Phone: _____

City, State, Zip: _____ Employer: _____

Dependent / Child Care Provider Information

Dependents' Names: 1._____ 2._____ 3._____

Birth Dates: 1._____ 2._____ 3._____

Relation to Participant: 1._____ 2._____ 3._____

Provider's Name: _____

Provider's Address: _____ City,State,Zip: _____

Provider's Phone: _____ Provider's Tax ID or SSN: _____

Provider's Signature: _____ Date: _____

• Request will not be processed without provider's signature.

Monthly Dependent Care Expenses

Dependent Care Expenses to be claimed for plan year: _____(enter plan year)

List Months in Plan Year	Monthly Expense	Explanation if Needed:
1._____	$_____	_____
2._____	$_____	_____
3._____	$_____	_____
4._____	$_____	_____
5._____	$_____	_____
6._____	$_____	_____
7._____	$_____	_____
8._____	$_____	_____
9._____	$_____	_____
10._____	$_____	_____
11._____	$_____	_____
12._____	$_____	_____
Total Annual Dependent Care Premium:	$_____	

Claims must be made for services incurred during the plan year. Requests include regularly incurred expenses under a binding agreement. No reimbursement may be approved thru a continual reimbursement program for any month in which Dependent Care Services are not rendered. It is your responsibility to advise the Plan Administrator of the cessation or interruption of such services.

Participant Agreement

I have verified that the information listed above and the information attached is true and correct. I understand that if any changes regarding the continual payments or services occur, The Advantage Group must be notified immediately. Failure to do so could result in additional taxes for which I would be responsible and liable.

_____ _____

Participant Signature Date

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