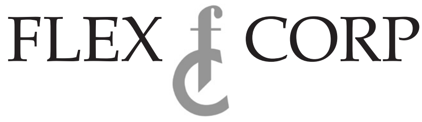

Dependent Care Request For Reimbursement
(Day Care Expenses)

When completed, mail this form and receipt to:

Flex Corp
5700 Northwest Central Drive, Suite 320
Houston, Texas 77092-2092
Phone: 713-939-5858 or 1-800-856-1816

Employer Name: ____________________

Employee Name: ____________________

Social Security Number: ____________________

Address: ____________________

City: ____________________ State: __________ Zip: __________

If this is a new address, please indicate by checking the box.

Dependent Information:

Name: ____________________ Date of Birth: __________ Age: _____ Relationship: __________

Name: ____________________ Date of Birth: __________ Age: _____ Relationship: __________

Name: ____________________ Date of Birth: __________ Age: _____ Relationship: __________

Name: ____________________ Date of Birth: __________ Age: _____ Relationship: __________

Name: ____________________ Date of Birth: __________ Age: _____ Relationship: __________

Period Covered From: __________ To: __________ Amount: $__________

Attach A Receipt Or Complete The Following:

Received $__________ on __________ from ____________________
(amount) (date) (payor)

for the care of children indicated above, for the period of time indicated above.

____
Original signature of Day Care Provider

Receipts or bills for dependent care should include the name and address of the day care provider, the name(s) of the person(s) receiving the care, the period of time during which the care was provided, and an itemized statement of the charges.

Please reimburse the above expenses from my dependent care reimbursement account in accordance with current guidelines. I certify that these expenses have not been reimbursed nor are they reimbursable from any other source.

____________________ ____________________
Employee Signature Date