DEPENDENT CARE RECEIPT FORM (THIS IS NOT A CLAIM)

Surency FLEX

Dear Dependent Care Provider:

The person named below is a participant in an employer sponsored Dependent Care Flexible Spending Account. The participant is requesting reimbursement from this pre-tax account for qualified dependent care expenses paid to you, the dependent care provider.

Employer _____ Plan Year _____

Employee Name (Last Name, First Name, MI) (Please Print) _____ Employee ID _____

The IRS requires that proof of service (a receipt) be provided by the care provider. Please use this form as that receipt by completing the Provider Information section and signing below.

Provider Information

Care Provider Name _____ Tax ID or Social Security Number _____

Date(s) of Care Provided _____ To _____

Dependent Name(s) Receiving Care _____

I verify that all information contained on this form regarding my dependent care services provided to the employee named above is accurate, and applicable amounts have been paid.

Care Provider Signature _____ Date _____

Return completed form back to Surency at email: flex@surency.com - fax: 316-272-4841
or mail: P.O. Box 789773, Wichita, KS 67278-9773
866-818-8805 | Surency.com