Professional Benefit Administrators, Inc.

DEPENDENT CARE RECURRING REIMBURSEMENT REQUEST FORM

Company Information

Company Name: _____

Employee Information

Employee Name:
Address:
ID Number:
Daytime Phone Number:

I verify that I make regular, ongoing payments to **Name of Dependent Care Provider:**
For **Name of Dependent(s):**

The charge for their care is $ _____ per _____ , beginning on ____/____/____ .
I authorize **Professional Benefit Administrators, Inc.** to automatically reimburse me the amount stated above from my Flexible Spending Dependent Care Account. I understand that the reimbursements will be made only up to the cash balance of my Flexible Spending Account. Unpaid claims are reimbursed as more money is credited to my account. Any unused funds remaining in the account at the end of the plan year will be forfeited.

I agree that if the amount changes or if, for any reason, such as illness or vacation, the expenses are not incurred as scheduled, I will notify **Professional Benefit Administrators, Inc.** immediately in writing.

This form is only valid for the current plan year.

Signed _____ Date _____
Employee

Provider Verification

I verify that the above charges are accurate as described.

Provider Signature	Federal Tax ID Number	Date

Please note: The dependent care provider must declare this as income on their tax return.

FAX TO:
Professional Benefit Administrators, Inc.
Fax: (630) 286-4660
Phone: (800) 435-5694