



**ACKNOWLEDGEMENT OF FIXED PAYMENTS
Dependent Care Spending Account**

I, (Provider) _____ hereby certify that (Employee) _____

Is paying \$ _____ Per _____ For Dependent Care Services for the period of

(Effective Date) _____ through (End Date) _____

Dependent's name _____ Relationship _____ DOB _____

Dependent's name _____ Relationship _____ DOB _____

Employee Address - _____ City - _____ St _____ Zip _____

Employee ID or SS#- _____

Provider Representative _____

Address _____

City _____ State _____ Zip Code _____

Tax ID or Social Security Number _____

Date _____

Employer Plan Services, Inc. will rely upon information provided by the Participating Employee, and shall not be liable for the completeness or truth of any information supplied. Employer Plan Services, Inc. shall have no obligation to any Participating Employee for any act, or failure to act provided Employer Plan Services, Inc. has acted in good faith in exercise of its powers as Claims Administrator of the Plan. The Participating Employee is responsible to maintain appropriate records and receipts for claims made under provisions of the Plan. Participating Employee may be required to supply proof of claims in the form of receipts or canceled checks. The Internal Revenue Service will also require verification in case of individual tax audit.

All completed forms should be returned to:

Employer Plan Services, Inc.
2180 North Loop West, Suite 400
Houston, Texas 77018

Phone: 866-369-0705

Fax: 713-369-0703

www.epsibenefitsinc.com