GROUP NAME __________
EMPLOYEE CAFETERIA PLAN
DEPENDENT CARE PROVIDER FORM

THIS PORTION TO BE COMPLETED BY DEPENDENT CARE PROVIDER

Date/s of care:____

Amount of reimbursement $:________________ (Attach receipts and/or itemized bills)

Dependent's name:________________________Relationship__________DOB___________
Dependent's name:________________________Relationship__________DOB___________
Dependent's name:________________________Relationship__________DOB___________
Dependent's name:________________________Relationship__________DOB___________

Name of day care provider:____

Address:____

City, State & Zip:____

Telephone No.:____

Social Security No. and/or Tax ID No.:_______________________________________

Provider Signature:_________________________________Date:____________________

THIS PORTION TO BE COMPLETED BY EMPLOYEE

Name of Employer:____

Name of Employee:____

Social Security No.:____

Address:____

City, State & Zip:____

EMPLOYER PLAN SERVICES, INC.
2180 North Loop West, #400
HOUSTON, TEXAS 77018
(800) 447-6588 OR (713) 932-8917
FAX # 713-369-0703