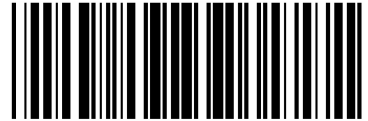


TOLL-FREE FAX: (877) 353 - 9236

Or, mail to: Claims Administrator, PO Box 14053, Lexington, KY 40512

DO NOT USE A FAX COVER SHEET to ensure speedy processing.



ACCOUNT HOLDER INFORMATION

Account holder information fields including Last Name, First Name, ID Code, Employer/Program Sponsor's Name, Zip Code, Birth Month/Day, and Email Address.

CERTIFICATION AND AUTHORIZATION

I certify that the information on this page is accurate and complete. I am requesting reimbursement for work-related dependent care expenses incurred by an eligible dependent...

Signature of Account Holder X _____ Date _____

CLAIMS FOR OUT-OF-POCKET EXPENSES

- Child care, Before/after school, Preschool, Summer day camp, Au pair, Senior day care, Other:

Claim 1 form with fields for Dependent's Name, Provider's Name, SSN, Service Start/End Dates, and Out-of-Pocket Cost.

Signature of Provider X _____ Date _____ Certifies services provided. Not required. Replaces need for receipt or other proof of service.

- Child care, Before/after school, Preschool, Summer day camp, Au pair, Senior day care, Other:

Claim 2 form with fields for Dependent's Name, Provider's Name, SSN, Service Start/End Dates, and Out-of-Pocket Cost.

Signature of Provider X _____ Date _____ Certifies services provided. Not required. Replaces need for receipt or other proof of service.

* Your ID Code is the last 4 digits of your Social Security Number, your Employee Number or other reference number assigned by your program sponsor.

TOTAL THIS FORM \$

YOU MUST HAVE PROVIDER SIGN FORM OR INCLUDE A RECEIPT OR OTHER APPROPRIATE PROOF OF SERVICE FOR EACH AMOUNT ABOVE.

MORE EXPENSES? Complete another form.