Dependent Care recurring expense form

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|  | **Instructions:** This form is used to request a recurring expense from your Dependent Care Account (DCA). By completing this form properly, you will not need to continue to provide documentation each month through the end of you plan year. A new form will need to be submitted each plan year. DCA is paid based on your per pay period contributions and you will not be paid more than what has been put into your account. Please complete all fields and provide the correct documentation if necessary.  **CLAIM FORM MUST BE FILLED OUT AND SIGNED TO BE PROCESSED FOR PAYMENTS.** |

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| 1. *Consumer Information* | | | |
| Company Name: |  | | |
| Employee Name: |  | SSN: |  |
| Phone Number: |  | E-mail: |  |

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| 1. *Dependent Information* | | | |
| Dependent Name: |  | DOB: |  |
| Dependent Name: |  | DOB: |  |
| Dependent Name: |  | DOB: |  |

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| 1. *Statement of Service* | | |
| Provider Name: |  | |
| Tax ID/SSN of Provider: |  | |
| Start Date of Services (MM/DD/YY): | |  |
| End Date of Services (MM/DD/YY): | |  |
| Total Monthly Amount for Services Rendered: | | **$** |
| *Note: If you have any changes to the above provider, dates or amount, please notify ABPlus immediately.* | | |

Option A:

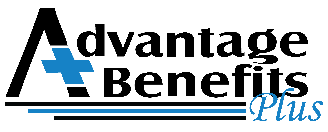
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|  | *Instructions for Option A: If you have used this provider before, Complete the form and have your authorized care provider verify, sign and date this section. By completing this section, you are NOT required to submit any documentation with this claim. Please sign the bottom of this form and turn into ABPlus via fax, mail or e-mail.* |

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| Signature of Provider: |  | Date: |  |

Option B:

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|  | *Instructions for Option B: If you have not used this provider before, Provide contract or documentation showing the provider name, Tax ID number or SSN of the provider, service start date, end date and amount of services. Submit documentation with this form completed filled out (except for Option A) to ABPlus via fax, mail or e-mail.* |

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| Signature of Employee: |  | Date: |  |



*Advantage Benefits Plus – Fax: 405-341-7588 – Phone: 405-341-7587  
17316 N May Ave, Suite A Edmond, OK 73012 – info@abplusonline.com*