Innovative Business Consultants

Dependent Care Reimbursement Form

Employer Name	Employee Email Address	
Employee Name	Employee Phone #	
Employee Address		
City	State	Zip

Dependent Care Expense

Period Beginning	Period Ending	Total Amount Requested for Reimbursement	Total Charge	Amount to Be Reimbursed

Signature of Service Provider:_____**Date:**_____

*****_Amount reimbursed from Dependent Care Expense account cannot exceed the amount employee has contributed to date. You must either ask your provider to sign this request for reimbursement or provide a receipt from your provider._

I hereby request payment from my flexible spending account for the expenses listed above. I certify that I have not been reimbursed for the expenses from any other health plan. I understand that any expenses reimbursed may not be used to claim on federal income tax deduction or credit. I hereby authorize deduction from my flexible spending account.

_____

Employee Signature Date

FAX COMPLETED FORM & SUPPORTING DOCUMENTS TO (712) 277-2622 or email ***claims@ibcins.biz. Retain original documents for your records.*

412 Water Street | Sioux City | IA | 51103
Phone (712) 277-2424