Innovative Business Consultants

Dependent Care Reimbursement Form

Employer Name	Employee Email Address
Employee Name	Employee Phone #

Employee Address		
City	State	Zip

Dependent Care Reimbursement Information

Dependent Name	Date of Birth	Period Beginning	Ending Period	Name of Service Provider	Amount to Be Reimbursed

Signature of Service Provider: ____Date:_________________

I certify that I am a qualified care provider as defined by the Internal Revenue Code and that the above expenses for services claimed above have been provided.

*****_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 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 (for a child under the age of 13 or other dependents that are physically and mentally incapable of taking care of themselves) while I was a participant in the plan. These services have already been provided and confirm that by requesting reimbursement here that I have not and will not seek reimbursement of this expense from any other plan or party.

Employee Signature: ____ Date: _______________

Fax completed form & supporting documents to (712) 277-2622 or email claims@ibcins.biz.
You can file claim reimbursements online through the Consumer Portal at https://ibcmember.LH1ondemand.com
Retain original documents for your records

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