STATEMENT OF DEPENDENT CARE EXPENSE

Submit this form, along with a completed claim form, to Benefit Resource, Inc.

Name of Employee *(please print clearly)*: _____ Date: _____

Dependent care services were provided for _____

by _____

for services provided on the dates _____/_____/_____ through _____/_____/_____.

Cost of these services: $ _____

_____ _____

Name of Provider (please print clearly) *Provider Signature*

(separate here)

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